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ABSTRACT

This report is a first year summative and formative evaluation of the Appalachian Adolescent Health Education Project (AAHEP), a program designed to reduce adolescent pregnancy and provide care for pregnant teenagers in East Tennessee. It attempts to determine the impact of the project on teenage pregnancy in the 15-county target area and the degree to which the project has met its objectives during the first year. It also provides information, conclusions, and recommendations to project managers for necessary project changes and planning. Three types of data are included: (1) a set of data from the Bureau of Statistics, Tennessee Department of Public Health and Environment; (2) data from project files; and (3) questionnaire data gathered from counselors, clients, and agency representatives. Baseline data is provided for future project assessment. The data provides information on services, pre-natal and post-natal referral groups, and dissemination. Interview summaries from delivered mothers (N=4), health care providers, and school personnel (N=9) are also included. Conclusions and recommendations are given for goals, program objectives, and management objectives. Ten figures, 31 tables, and questionnaires used in the evaluation are provided. (ABB)

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APPALACHIAN ADOLESCENT HEALTH EDUCATION
PROJECT (AAHEP)

FIRST-YEAR EVALUATION REPORT
10/1/82 - 9/30/83

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12/83

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I. INTRODUCTION

Evaluation of the first year of the Appalachian Adolescent Health Education Project (AAHEP) has been tentative and exploratory in many ways. This project is highly dispersed, serving a fifteen-county area which has a primarily white, rural, Appalachian population. It is difficult to demonstrate impact of the project on the area since 1) the area is so large (over 6000 sq. mi.), 2) so few persons in an area are served, and 3) since the project is so new. Up-to-date baseline data were not easily available at the beginning of the project. New "baseline" data were obtained at the end of the project's first year and these should help in future years.

Because of its diffuse and dispersed nature, AAHEP has had unusual problems occasioned by transportation and communication. Also, AAHEP experienced some "birthing" problems in getting organized and operational. Original commitments by the Tennessee Department of Health to house counselors at Health Department sites were not forthcoming, and the project needed to identify new sites for counselors' offices. This was time-consuming and necessitated development of new working relationships which, although they proved effective later, caused some delay in getting things underway. Some of these problems have been documented in the Interim Evaluation Report, May, 1983.*

The project needed time to develop staff working relationships. There was some staff turnover which caused some delays and setbacks, and there was a need to establish lines of communication and responsibility for the counselors. The project was not fully funded as originally conceptualized, resulting in a necessary cutback in the proposed staff. This caused redistribution of responsibility by counties and a reassessment of work priorities. During the year, the staff worked to solve these problems and the project operated fairly smoothly for the last several months.

During a site visit, federal program officers suggested some changes in project operations and a re-focusing of efforts. Some of these changes have been made, and additional changes are already scheduled for the 1983-84 operating year. (These will be discussed later.)

*DuVall, L., Campbell, E., and Achilles, C. Interim Evaluation Report. AAHEP. Morristown, TN. May, 1983.

Most of the substantive, client-oriented data have been collected on a continuous basis and provided to the evaluators by project counselors who observed accepted confidentiality (protection of human subjects) procedures. These data are one important component of the AAHEP evaluation. However, the evaluators had no control over these data and simply have reported (and analyzed) what was provided. The evaluators have then developed some evaluative statements based upon those reported data. Attempts have been made to verify the data. The evaluation team members feel comfortable that the data reported in the evaluation document are accurate and clearly and fairly reflect AAHEP operations.

In summary, it seems fair to say that AAHEP--like most new projects--experienced some problems in getting started. These problems were occasioned by several factors, including some not within the total control of the project. Also, some difficulties were caused by the diffuse nature of this particular project. During the first year of operation most problems have been satisfactorily overcome and an effective standard operating procedure has evolved.

Timelines for Key Activities

Page 3 of the Interim Evaluation provided a few key dates of major events of early AAHEP efforts. The dates below expand that earlier list.

<u>1983</u>	<u>Activity</u>
May 19-20	Site Visit by OAPP
June	New Data Forms and Formats (from OAPP)
Early July	Approval for Microcomputer (by phone)
July 25	Installation of Microcomputer (Hardware)
Sept.	Specific Data Formats Required (see June) Meeting with Health Department to Develop new Working Relationships (In-kind, also)
Sept. 22	"Intent to Terminate" Letters Sent
Sept. 30	Microcomputer Software Package Operational

Objectives and Goals

Project objectives and goals appear in Figure 1 on the following pages. These give direction both to the project and to the evaluation.

APPALACHIAN ADOLESCENT HEALTH EDUCATION PROJECT
Evaluation Data Checklist

GOAL/OBJECTIVE	ACCOMPLISHMENT INDICATOR	DATA NEEDED	BASELINE/SOURCE
GOAL 1: To reduce adolescent premarital sexual relations and adolescent pregnancy	1.1 Reduced number of adolescent pregnancies	1.1 Number of adolescent pregnancies by county	1.1 SDPH*
	1.2 Reduced incidence of VD among adolescents	1.2 Number of cases of VD among adol. by county	1.2 SDPH
	1.3 Reduced number of abortions among adolescents	1.3 Number of abortions among adolescents by county	1.3 SDPH
GOAL 2: To improve the level of medical and developmental care provided to pregnant adolescents	2.1 Increased prenatal care	2.1 a Number of third trimester care patients b Number of visits for medical care during pregnancy	2.1 a SDPH b SDPH
	2.2 Reduced number of low weight babies (LWB)	2.2 Number of LWB born to adolescents by county	2.2 SDPH
	2.3 Reduced number of neonatal and infant deaths to adolescent mothers	2.3 Number of neonatal and infant deaths to adolescent mothers by county	2.3 SDPH
OBJECTIVE 1: To coordinate available prevention and care services to maximize the impact of existing programs	1.1 Increased contacts and referrals to cooperating agencies	1.1 a Number of contacts with agencies b Number of contacts among agencies	1.1 a Counselor logs b Agency logs
	1.2 Increased number of referrals to more than one agency	1.2 Number of multi-agency referrals	1.2 Counselor logs

*State Department of Public Health

GOAL/OBJECTIVE	ACCOMPLISHMENT INDICATOR	DATA NEEDED	BASELINE/SOURCE
OBJECTIVE 2: To make additional resource personnel available to adolescents and their families	2.1 Increased number of adolescents using existing resource personnel	2.1 Number of clients using resources	2.1 Counselor files
	2.2 Increased number of families of clients using existing resource personnel	2.2 Number of families using resources	2.2 Agency information
		2.3 Resources used by clients and families	2.3 Counselor and Agency's files
OBJECTIVE 3: To generate the resources needed to continue AAHEP's services in the absence of federal funds	3.1 Commitment to program continuation at termination of federal funding	3.1 Number of contacts re program continuation	3.1, 3.2 Program personnel and files
		3.2 Indication of intentions of contacts re program continuation	
OBJECTIVE 4: To arrange for appropriate utilization of prenatal and postnatal services by adolescents regardless of their proximity to available services	4.1 Appropriate prenatal and postnatal care for clients	4.1 Documentation of care arranged on behalf of clients	4.1 Counselor files
		4.2 Records of distance from clients' homes to nearest care facility	4.2 Perceptions of value of assistance
OBJECTIVE 5: To provide individual assistance to pregnant adolescents in making arrangements for their delivery	5.1 Individual assistance provided pregnant adolescents prior to delivery	5.1 Tabulation of types of assistance provided	5.1 Counselor files

GOAL/OBJECTIVE	ACCOMPLISHMENT INDICATOR	DATA NEEDED	BASELINE/SOURCE
OBJECTIVE 6: To provide more adequate education of adolescents related to sexuality including continuous availability of information	6.1 Existence of education programs for adolescents re sexuality, including: a. School programs b. Information centers c. Inservice for teachers d. Peer groups in school	6.1 Tabulation of types of programs offered 6.2 Description of information provided 6.3 Description of materials developed 6.4 Tabulation of characteristics of persons using and attending programs	6.1 - 6.4 Counselor files and actual materials
OBJECTIVE 7: To create a system for involving families and religious organizations in the education of adolescents related to sexual responsibilities	7.1 Families are more involved in informational programs for adolescents 7.2 Families involved in parent groups in churches and the community 7.3 Active participation in sex education by religious organizations	7.1 a Number of families involved in establishing and attending informational programs b Nature of "family," i.e., nuclear, single parent, etc. 7.2 a Number of parent groups b Location of meetings c Topics of meetings d Activities undertaken 7.3 a Number and description of programs b Number and types of persons involved, i.e., clergy, lay officers c Facilities provided	7.1 Counselor files 7.2 a Counselor files b - d Minutes of meetings 7.3 Counselor files

MANAGEMENT OBJECTIVES	ACCOMPLISHMENT INDICATOR	DATA NEEDED	BASELINE/SOURCE
OBJECTIVE 1: To establish and maintain AAHEP in the target area	1.1 Existence of AAHEP	1.1 a Minutes, logs and reports b On-site interviews with clients and staff	1.1 a Program files b Interview reports
OBJECTIVE 2: To manage, operate, and evaluate the progress of AAHEP	2.1 Accomplishment of goals and objectives 2.2 Objectives met within well-managed budget 2.3 Independent CPA audit	2.1 a Program data about clients and programs b Interviews with agency personnel c Program data re progress 2.2 Program accounting 2.3 CPA accounting	2.1 a Program files b Interview reports c Program progress report 2.2 Program files 2.3 CPA report
OBJECTIVE 3: To evaluate the AAHEP and disseminate information about its purposes, programs, products, and results	3.1 Completion of evaluation reports in timely fashion 3.2 Completion and execution of dissemination plan	3.1 Evaluation 3.2 a Dissemination plan b Evidence of action taken to implement the plan	3.1 Evaluation report 3.2 Program files

II. METHODOLOGY

This report encompasses the first 12 months of the operation of the AAHEP Project. It represents the efforts of a Project Director, Associate Directors for Counseling and Education, and nine counselors who worked in 15 counties.

The focus of the report is both summative and formative. The summative focus derives from an attempt by the evaluators to determine the impact of the project on teenage pregnancy in the target area and the degree to which the project has met its objectives during the first year of operations. The report is also formative in that it provides information, conclusions and recommendations to project managers so that necessary changes can be made in project operations and future project planning can be based on information generated during the first year of operations.

Data included in this report are of three types. The first is a set of data obtained from the Bureau of Statistics, Tennessee Department of Public Health and Environment (TDPHE). These data are collected routinely by the TDPHE from hospitals and county governments. Data for the calendar years 1977 through 1982 are included. Also included are data for the first nine months of 1983. In order to make comparisons for the full seven years, projections for 1983 were developed on the basis of the available data. The method for making these projections is explained in Section III, p. 11.

The second type of data is data obtained from project files. Counselors completed information sheets about each of their clients who had delivered babies during AAHEP's first year of operations. This information was taken from the office files maintained by each counselor. In order to insure client anonymity, evaluators did not examine these files, and reference to individuals was made by using first name and last initial only.

At the end of each month, every counselor completed a report form which detailed his/her activities for that month. This report was filed with the Project Director. The nine counselor reports were compiled into a single monthly project report. At the end of the year the monthly reports were combined into a single year-end project report. These monthly and year-end reports were the primary source of information about services provided by project staff members.

The third type of data are questionnaire data. Counselors were asked to complete a questionnaire concerning their work and their perceptions of the project (Appendix A). Counselors also completed a questionnaire about each client who had delivered on or before September 30, 1983 (Appendix B). Selected clients were interviewed by two members of the evaluation team using an interview guide (Appendix C). Finally, representatives of agencies who had worked with AAHEP personnel were interviewed, either in person by one or more members of the evaluation team or by telephone. Two interview guides were used in collecting these data. One guide was used when interviewing health service personnel (Appendix D), and a second guide was used in interviewing school and other agency personnel (Appendix E).

The questionnaires described above resulted from a series of meetings held by the evaluation team with project staff members. At the outset of those meetings, the primary objective of the evaluation effort was identified as determining the impact of the project on the 15-county area. Initially, it was agreed that this could be done by examining the care and prevention components as separate but related efforts. Accordingly, it was judged essential to obtain information about every client who had obtained project services through the care component. In addition, it was agreed that qualitative information was necessary about care services provided.

Besides documenting project implementation and identifying areas for improvement, the Interim Evaluation Report (DuVall, Campbell, Achilles: May, 1983) brought together baseline information that the evaluators hoped would be useful in later assessment of project impact on teenage pregnancy in the area. These data were not up-to-date, and the current report provides additional baseline data. Although the evaluation team hopes to develop impact information using the baseline data, it appears (as noted in a 7/16/83 letter from Dr. Sonenstein, HSS) that this project "does not appear likely to involve sufficient proportions of county adolescents to justify measuring impact in terms of changes in area natality and similar statistics." Thus, the current evaluation design and procedures have been broadened and revised to focus primarily on the impact of project efforts on individual clients.

Initially the evaluation sought to separate the prevention and care components. This has proved to be extremely difficult without clearer definition of each; counselors are able to estimate some division of effort related to these components but individual activities pursued during the year were not clearly identifiable as discreet care or prevention activities. Thus, prevention and care efforts are presented as part of a unified evaluation report; where possible, distinctions have been made.

To obtain qualitative information, the evaluation team requested the names of six clients who 1) were willing to be interviewed, 2) whose schedules made them available within a two-week period of time (October 10 through October 22, 1983), and 3) who could be reached to schedule an appointment. The names of four such clients were obtained; these four were subsequently interviewed (approximately a 10 percent sample).

The clients who were interviewed were seen as the center of a cluster of participants who could provide qualitative data. For each of the clients interviewed, at least one school official familiar with her case and at least one person from the medical profession who provided care during her pregnancy were interviewed. This cluster of people provided information which the evaluation team believed would help establish a comprehensive overview of the quality of care provided. In addition, members of the family of the four clients were interviewed when possible.

Although interview data were collected from persons representing a cluster of participants, those data are not reported by cluster. Data are reported by roles of interviewees in the cluster. Thus, for instance, comments by school personnel are reported as a single set of data.

Finally, the evaluation team met with the counselors to obtain their comments about the program and its operation. Individual evaluation team members met with project administrators for the same purpose. Unobtrusive measures included unscheduled and unsolicited comments about AAHEP and serendipitous findings such as the existence of heretofore undiscovered resources that could assist the project.

The general approach taken to the design of the evaluation plan and the collection and analysis of data conforms to the evaluation plan developed at the beginning of the project. That plan, shown in Figure 1, was derived from the design outlined in the proposal and continues to be the operational guide for the evaluation effort (see figure 1, pages 4-7).

III. BASELINE DATA*

Data in this section were obtained from the Bureau of Health Statistics, Tennessee State Department of Public Health and Environment. They include statistics from calendar years 1977 through 1982. In addition, data are presented for the period January 1 through September 30, 1983. Statistics for 1983 should be considered as tentative at this date (12/83). Since all data represent the county of residence of adolescent mothers, some births recorded in other states to mothers who are target-county residents may not be included in the totals for 1983 shown here. These births may not be reported until the end of the calendar year.

In order to show comparisons for complete calendar years, it was necessary to develop full-year projections for 1983 since current data included only nine months of the year. This projection was based on the assumption that rates were steady across the full year. Therefore, all 1983 figures include a projection of an additional 25 percent of the figures tallied during the first nine months. As a result, the 1983 data should be used only to identify possible trends and cannot be taken as an absolutely accurate account of adolescent pregnancy during the year.

In Figure 2, the total of recorded births to adolescent mothers in the 15 county AAHEP Area is shown. From 1977 through 1983, the number of births remained rather constant. In 1982, the total dropped almost 100 births from the 1977 figure. If the 1983 projection proves to be accurate, 1983 will represent a dramatic drop from previous levels. We can see a three-year trend of declining adolescent motherhood with a considerable decline in 1983.

In Table 1, the data show a decline in numbers of abortions and fetal deaths since 1980. If the 1983 data confirm the direction indicated by the projected figures, a four-year trend of declining abortion rates will be established. The number of fetal deaths shows a dramatic decrease, more than 50 percent in three years.

In Table 2, the numbers of births to mothers aged twelve to nineteen are shown. Also shown are the percentages of the yearly total of births to adolescents. The percentages in this table and in Tables 4 and 5 were computed to show proportional relationships from year to year. For instance,

*Initial baseline data appear in the Interim Report. Current figures update the original baseline.

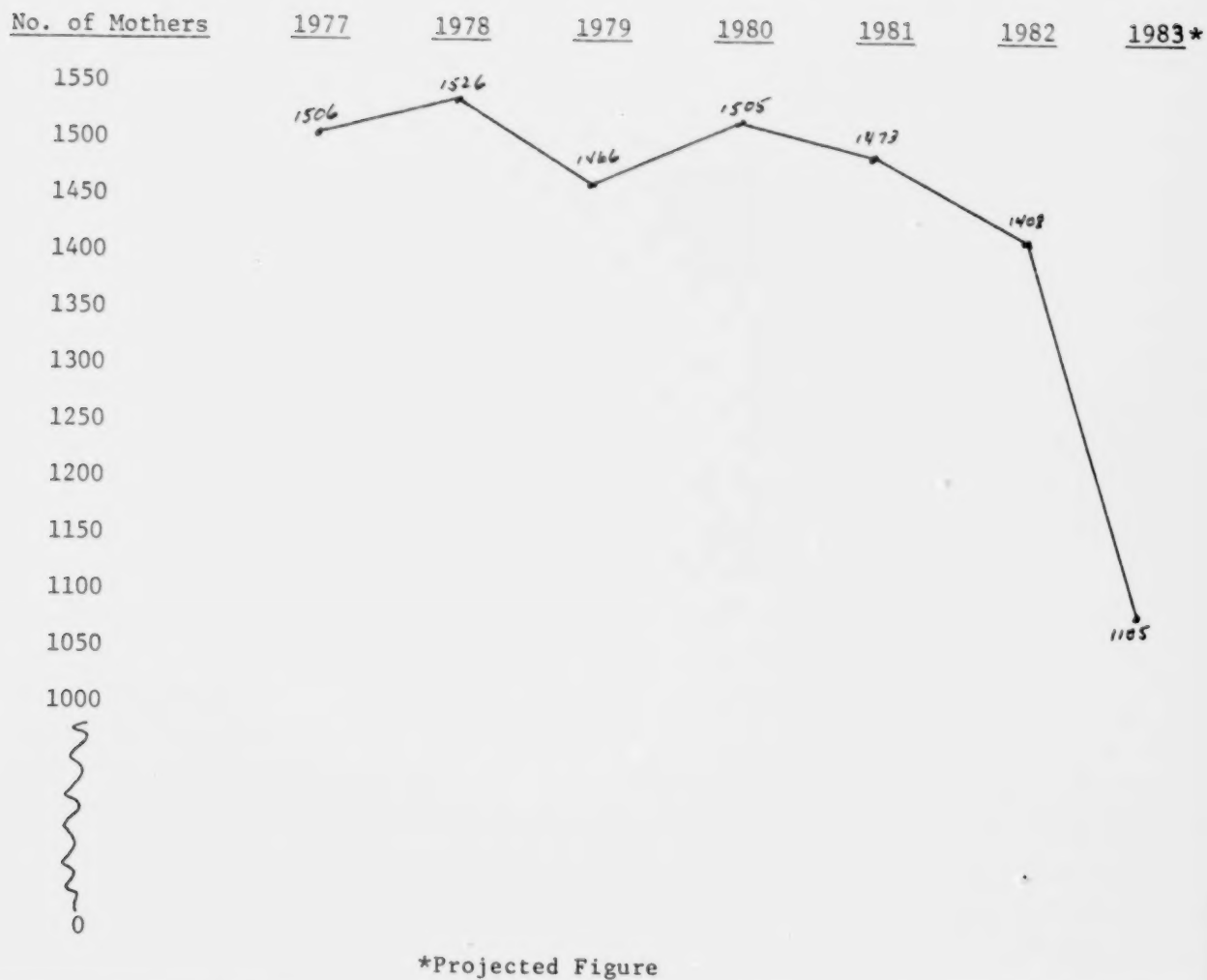


Figure 2 Graph of Number of Mothers Ages 12-19,
15 Counties AAHEP Area, 1977-1983

TABLE 1

Number of Abortions, Live Births and Fetal Deaths of
Mothers Aged 10-19, 15 Counties of AAHEP,
By County, (1980-1983)

County	Number of Abortions				Number of Live Births				Number of Fetal Deaths			
	1980	81	82	83*	1980	81	82	83*	1980	81	82	83+
Anderson	94	82	86	84	158	155	143	116	2	0	0	
Blount	106	104	95	89	181	186	163	139	0	0	1	
Campbell	28	21	20	16	146	126	136	117	2	0	0	
Claiborne	9	17	12	15	67	62	72	25	1	0	0	
Cocke	32	34	42	33	103	100	100	77	4	1	0	
Grainger	19	11	11	11	46	55	48	40	0	1	0	
Hamblen	60	56	63	57	141	148	137	92	1	2	0	
Jefferson	39	43	42	25	91	69	70	56	0	0	0	
Louden	30	28	42	37	68	62	69	59	0	0	1	
Monroe	36	30	26	36	112	90	100	78	0	1	0	
Morgan	10	4	13	7	57	60	56	43	1	0	0	
Roane	56	54	48	52	125	134	104	85	1	1	2	
Scott	10	11	7	5	74	81	56	71	0	2	1	
Sevier	69	50	55	51	99	107	117	78	1	2	1	
Union	7	5	8	11	37	38	37	29	1	0	0	
Total	605	550	570	529	1505	1473	1408	1105	14	10	6	

* Projected figures for 1983

+ No data available

TABLE 2

Number of Births and Percentage of Yearly Number
By Age of Mother for the 15 County AAHEP
Area, 1977-1983

<u>Age of Mother</u>	<u>Years</u>	<u>Number</u>	<u>% of N*</u>	<u>Age</u>	<u>Years</u>	<u>Number</u>	<u>% of N</u>
12	1977	0	1	16	77	182	12.1
	78	1			78	196	12.9
	79	1			79	181	12.3
	80	0			80	189	12.6
	81	0			81	189	12.8
	82	0			82	177	12.6
	83	1			83	116	10.5
13	77	3	Less than 1 percent	17	77	331	22.0
	78	3			78	314	20.6
	79	5			79	319	21.8
	80	4			80	322	21.4
	81	1			81	292	19.8
	82	2			82	273	19.4
	83	1			83	211	19.1
14	77	28	1.9	18	77	419	27.8
	78	28	1.9		78	443	29.0
	79	28	1.9		79	348	23.7
	80	20	1.3		80	394	26.2
	81	14	.9		82	419	28.4
	82	17	1.2		82	391	22.8
	83	14	1.2		83	304	22.5
15	77	97	6.4	19	77	416	29.6
	78	89	5.8		78	432	28.6
	79	88	6.0		79	496	33.8
	80	87	4.7		80	525	33.6
	81	78	5.3		81	480	32.6
	82	68	4.8		82	480	34.1
	83	54	4.9		83	417	36.8

* Number of Births Per Year appears in Figure 2, p. 12.

for 14-year-old mothers the number of births has decreased from 28 to 14 over seven years. The total number of births, however, has decreased from 1506 (1977) to 1105 (1983, projected) over the same seven years. Due to the differences of total numbers from year to year it is important to plot proportional differences among the age groups to determine possible trends over time.

The proportions are derived in terms of percents, by year, based on number of births to each age group of mothers divided by total births for that year. Thus, for 1977 the percents (1.9, 6.4, 12.1, 22, 27.8, 29.6) total 99.8 (with two age groups as "negligible").

In Figure 3, it can be seen that the numbers of births to adolescents indicate that some shift is occurring within the 12-19 year age span. In the 13, 14, and 15 year olds, the number of births diminished by at least half over the seven years shown. Among the 17 year olds, the drop was approximately one-third; among the 18 year olds, about one-fourth; and among the 19 year olds, one-tenth. When the number of births each year within each age group are compared as a percent of the yearly total (Figure 4), the percentages remain relatively constant with the exception of one age group. In the 19-year-old group, the percentage of total births shows a steady rise over the seven years.

Data in Table 3 show that the largest portion of pregnant teenagers make from 7 to 10 visits for pre-natal, medical care. The number of mothers making 0-2 pre-natal, medical care visits has dropped almost 50 percent, and the number making 15-20 visits has increased more than 100 percent.

Yearly comparisons of the numbers shown in Table 3 are presented in Figure 5.

In Figure 6, the comparison of percentages shown in Table 3 is presented. There appears to be a trend towards more pre-natal, medical care as shown by the percentage increase, over the seven years, of mothers making 11-14 and 15-20 visits.

In Table 4 the numbers of mothers receiving prenatal care are categorized by the trimester in which initial care was received. The first trimester is the period in which the largest number and the largest percentage of mothers receive initial care.

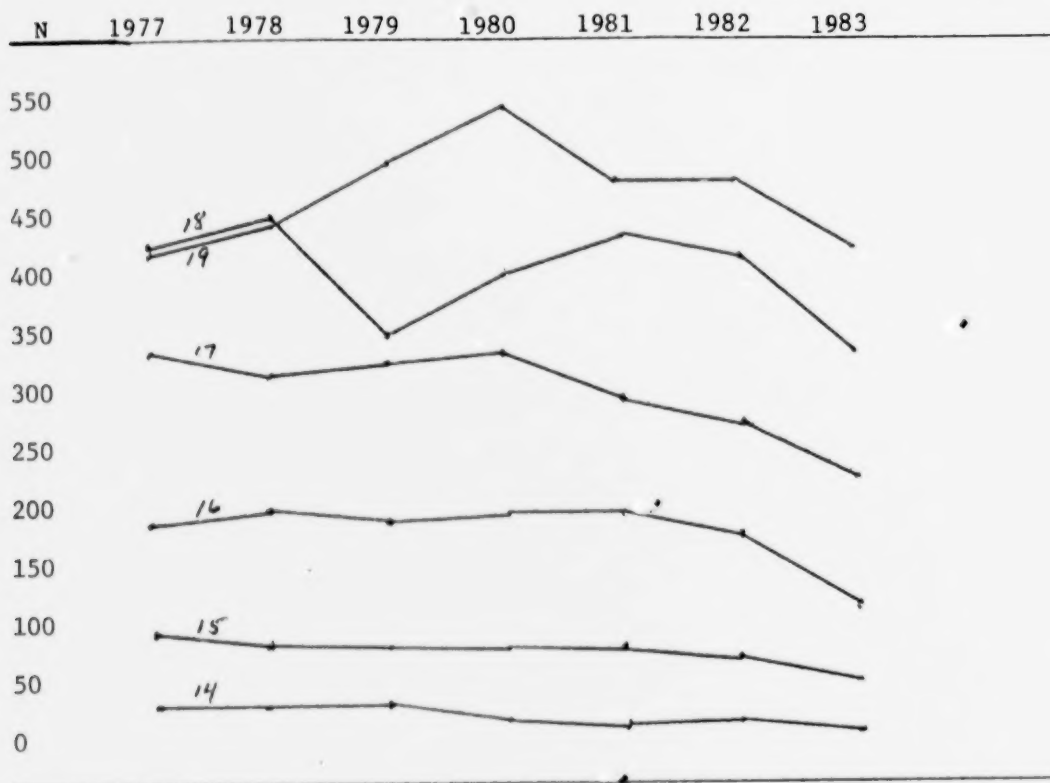


Figure 3 Comparison of Numbers of Births to Mothers Aged 14-19 in the 15 County AAHEP Area, 1977-1983.

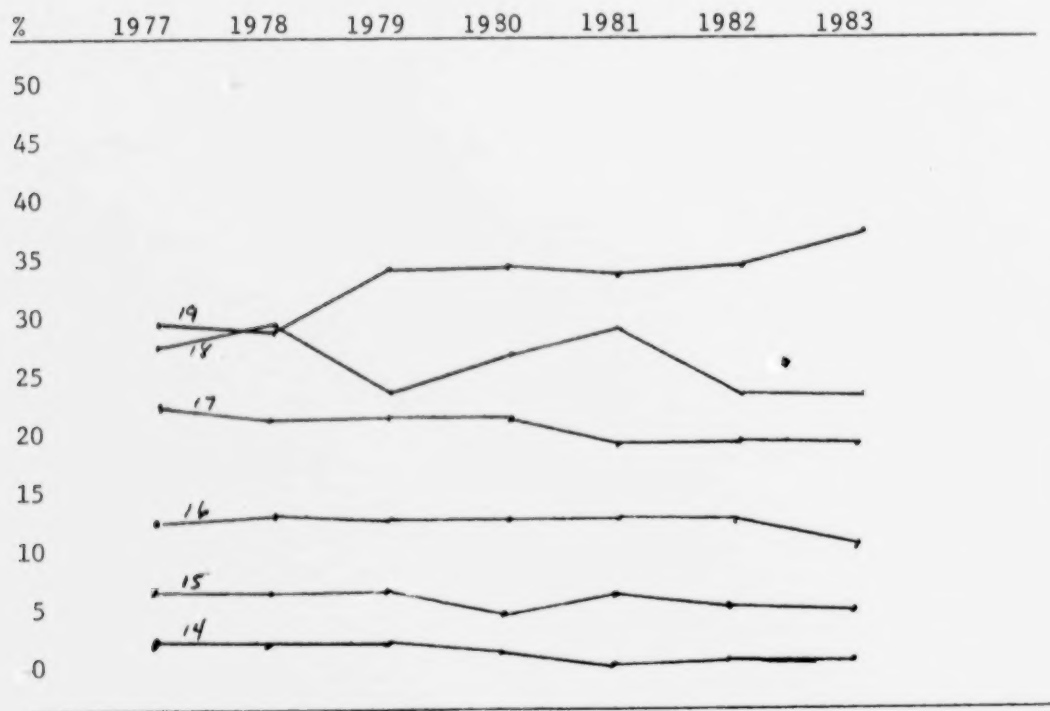


Figure 4 Comparison of Percent of Number of Yearly Births to Mothers Aged 14-19 in 15 County AAHEP Area, 1977-1983.

TABLE 3

Number and Percent of Yearly Number of Mothers
Aged 12-19 Receiving Pre-Natal Medical Care, 15
County AAHEP Area, by Number of Visits
1977-1983

Number of Visits	Years*	Number of Mothers	% of Yearly N**	Number of Visits	Years	Number of Mothers	% of Yearly N
Unknown	1977	141	9.4	11-14	1977	330	21.9
	78	99	6.4		78	360	20.6
	79	49	3.3		79	364	24.9
	80	30	2.0		80	417	27.7
	81	33	2.2		81	418	28.4
	82	51	3.6		82	362	25.7
	83	24	2.1		83	313	28.3
0-2	1977	94	6.2	15-20	1977	48	3.2
	78	85	5.6		78	62	4.1
	79	76	5.2		79	113	7.7
	80	76	5.1		80	97	6.4
	81	59	4.0		81	99	6.7
	82	85	6.0		82	97	6.9
	83	52	4.7		83	110	10.0
3-6	1977	332	22.0	20+	1977	6	.4
	78	322	21.0		78	10	.7
	79	250	17.0		79	13	.9
	80	259	17.2		80	16	1.1
	81	251	17.0		81	11	.8
	82	260	18.5		82	4	.3
	83	195	17.6		83	2	.2
7-10	1977	555	36.9				
	78	588	38.5				
	79	535	36.5				
	80	610	40.5				
	81	602	40.9				
	82	549	39.0				
	83	409	37.0				

* 1983 figures are projected figures.

**Yearly N from Figure 2, p. 12.

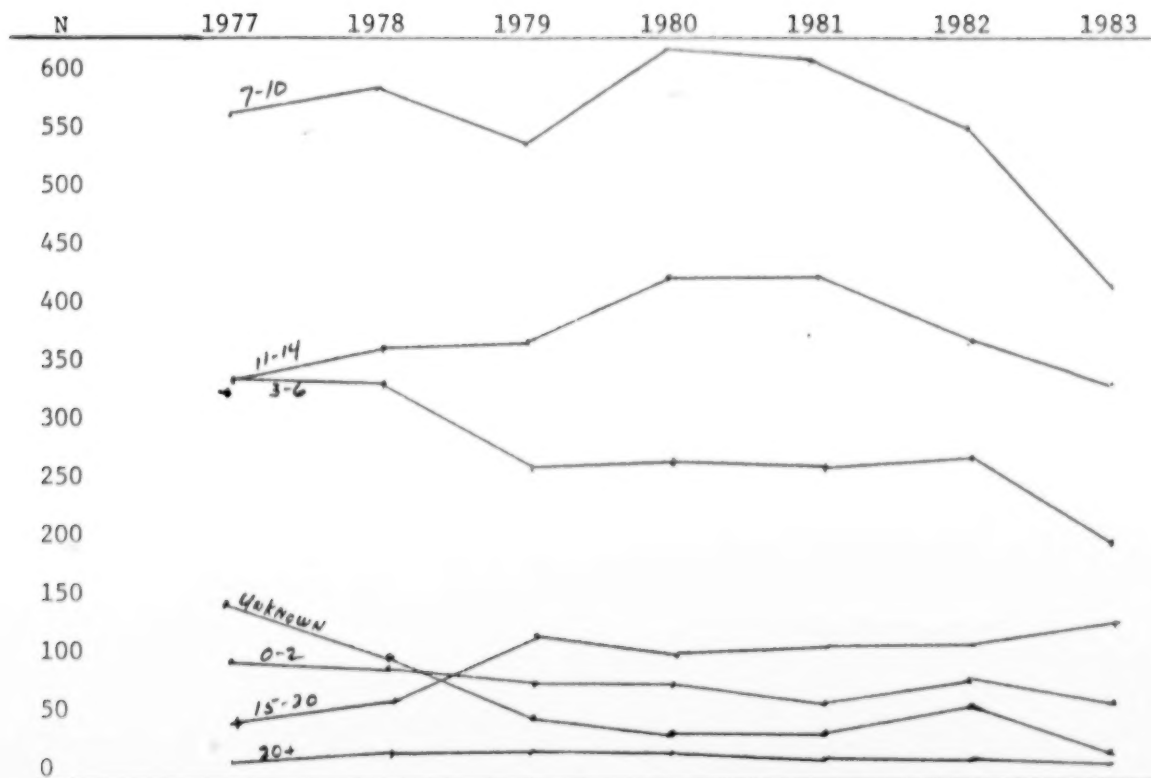


Figure 5 Comparison of Number of Pre-Natal Medical Care Visits by Mothers Aged 12-19 in the 15 County AAHEP Area, 1977-1983

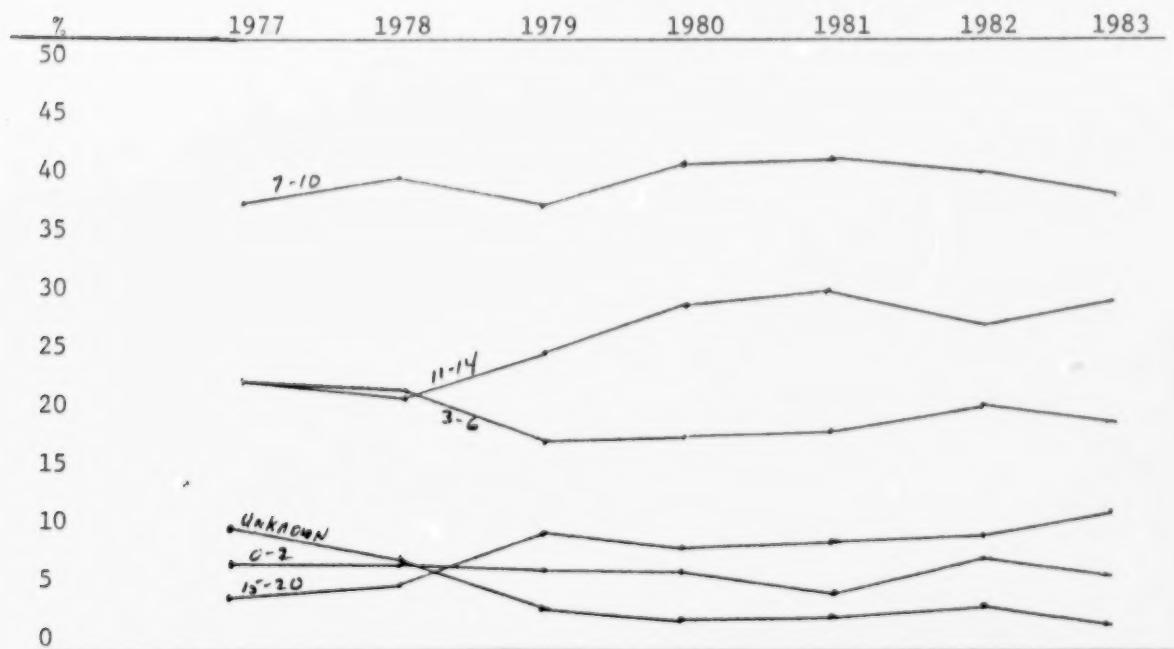


Figure 6 Comparison of Percent of Yearly Pre-Natal Medical Visits by Mothers Aged 12-19 in the 15 County AAHEP Area, 1977-83

TABLE 4

Number and Percent of Yearly Number of Mothers Aged 12-19
Receiving Medical Pre-Natal Care in the 15 County
AAHEP Area, By Trimester of Initial Care
1977-1983

Trimester	Years*	Number of Mothers	% of Yearly N**	Trimester	Years	Number of Mothers	% of Yearly N**
Unknown	1977	141	9.4	2nd	1977	536	35.6
	78	99	6.5		78	541	35.5
	79	49	3.3		79	502	34.2
	80	30	2.0		80	530	35.2
	81	33	2.2		81	519	35.2
	82	51	3.6		82	505	35.9
	83	26	2.4		83	409	37.0
None	1977	18	1.2	3rd	1977	118	7.8
	78	26	1.7		78	118	7.7
	79	32	2.2		79	96	6.5
	80	23	1.5		80	98	6.5
	81	16	1.1		81	113	7.7
	82	38	2.7		82	99	7.0
	83	19	1.7		83	89	8.1
1st	1977	693	46.0				
	78	742	48.6				
	79	787	53.6				
	80	824	54.8				
	81	792	53.8				
	82	715	50.8				
	83	565	51.1				

* 1983 figures are projected figures.

** From Figure 2, p. 12.

Comparison of numbers of mothers receiving pre-natal medical care by trimester of initial care is shown in Figure 7. There has been a decrease in numbers receiving 1st and 2nd trimester medical care, but these decreases are paralleled closely by a decrease in total births to teenage mothers. The number receiving 3rd trimester care or no pre-natal medical care has remained relatively constant.

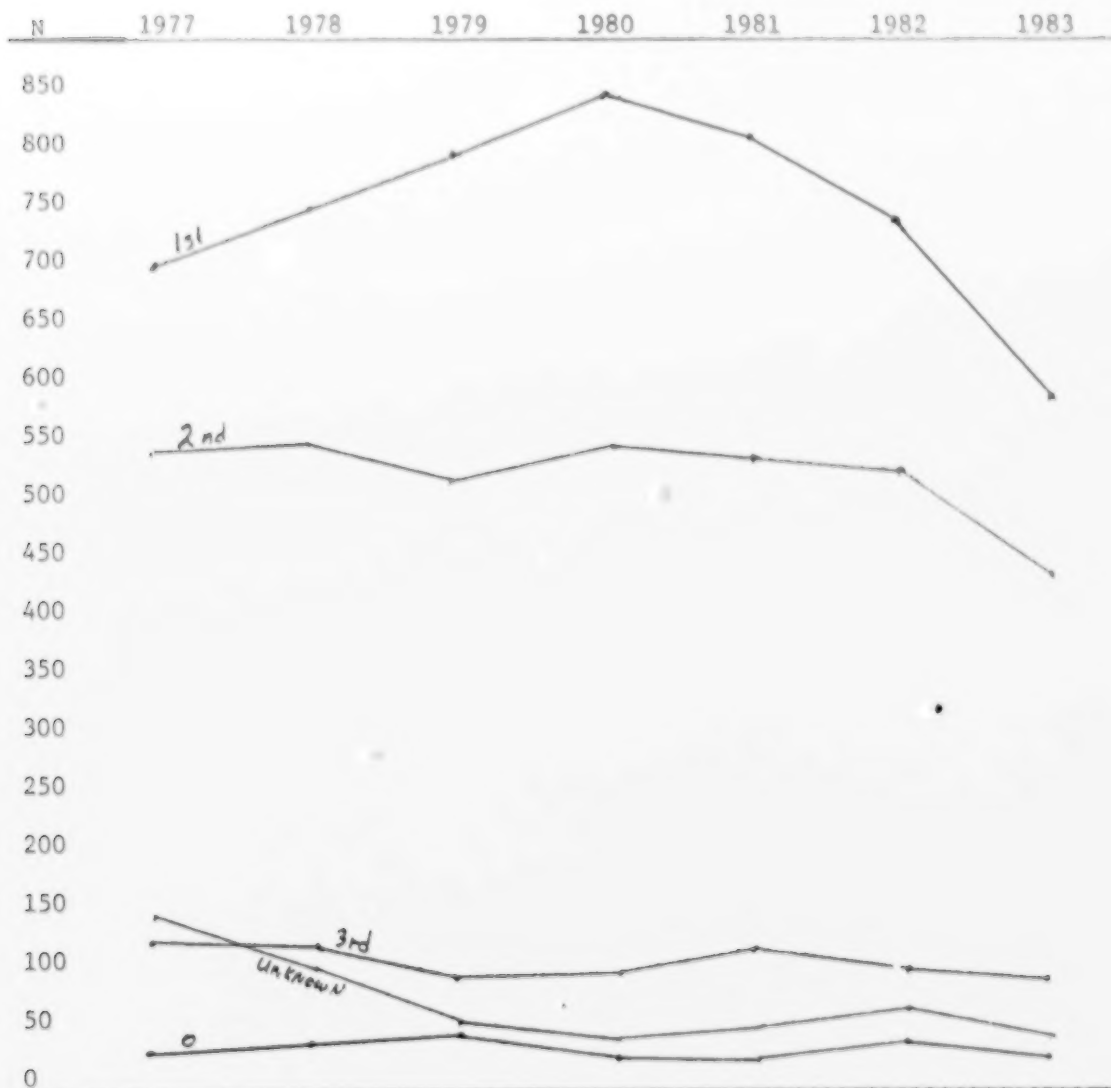


Figure 7 Comparison of Numbers of Mothers Aged 12-19 Receiving Pre-Natal Medical Care in the 15 County AAHEP Area by Trimester of Initial Care, 1977-1983

Comparisons of percentages of initial trimester pre-natal, medical care show little change. A slight increase in first trimester care is indicated, but that difference is only about 4 percent. Additional data will be needed to determine a trend (Figure 8).

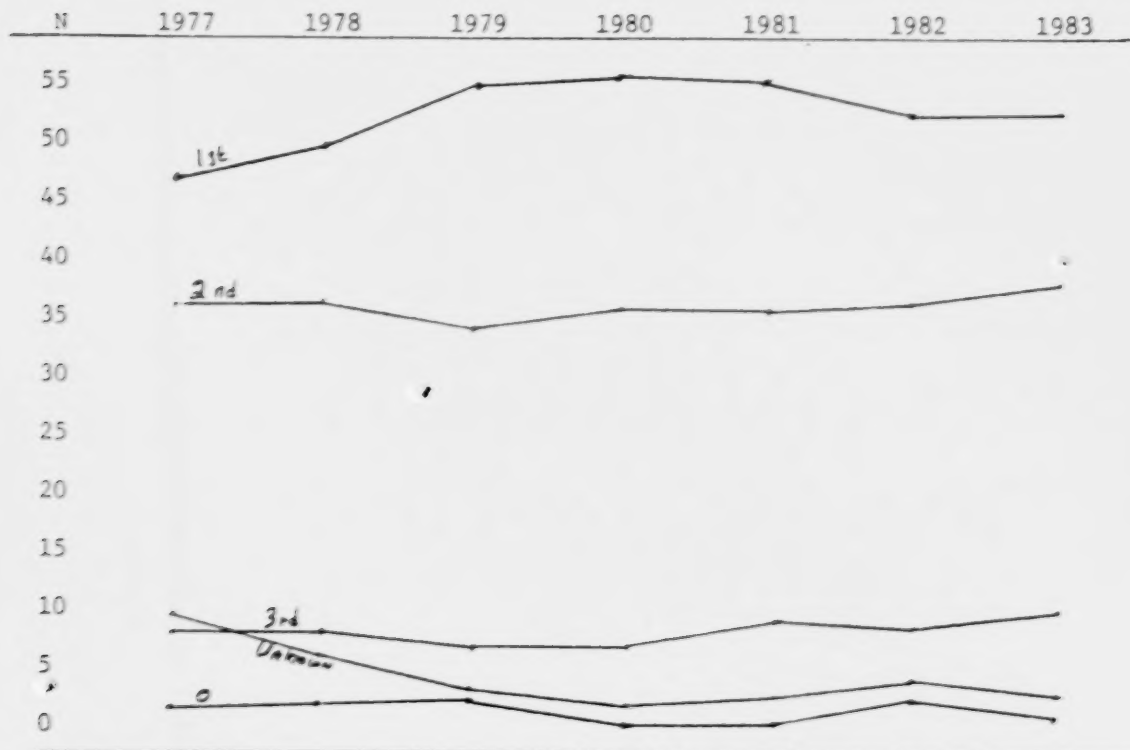


Figure 8 Comparison of Percent of Yearly Numbers of Mothers Aged 12-19 Receiving Pre-Natal Medical Care in the 15 County AAHEP Area by Trimester of Initial Care, 1977-1983

The number of low-weight births to teenaged mothers in the 15 county area is shown in Table 5. The number of low-weight births to mothers who receive no pre-natal care appears to be rising. In contrast, the number of low-weight births to mothers who receive 1st trimester initial care appears to be dropping.

TABLE 5
Number of Low Weight Births to Mothers Aged 10-19, by
Trimester of Initial Care, in 15 AAHEP Counties,
1980-1983

	1980	1981	1982	1983*
Unknown	4	5	4	5
No Pre-Natal Care	1	3	13	5
1st Trimester	75	67	63	43
2nd Trimester	35	43	50	35
3rd Trimester	6	9	5	5
Total	121	127	135	93

*Projected Figures

Summary. Due to the preliminary nature of the 1983 data, care must be exercised in interpretation. This limitation notwithstanding, it appears that teenage pregnancy in the 15 county area has dropped substantially since 1977. The most dramatic change has been in 1983 (if the 1983 figures prove to be accurate). There is a trend, however. Teenage pregnancies are declining.

In addition to the decline in teenage pregnancies in the area, there appears to be a shift in the numbers of births from younger to older teenagers. The percentage of births in each of the years to mothers aged 13 to 17 has remained relatively constant or declined slightly. On the other hand, the percentage of births to 19-year-olds has increased.

Pregnant teenagers appear to be receiving more pre-natal care than previously. The number of mothers who make 0 to 2 pre-natal visits for medical care is decreasing, and the number of mothers who make more than 10 visits is increasing. This may be related to the decrease in number of low birth-weight babies born to mothers who receive first trimester care.

These results, if the trends continue, are in the direction of hoped-for gains for AAHEP. That is, AAHEP's objectives were for lower teenage pregnancies, better and earlier prenatal care, and better, more healthy babies of those born to teenage mothers.

IV. SERVICES

Tables 6 through 13 provide an overview of services provided by AAHEP staff members during the year and a summary of the types of persons served. Figures reported in this section were taken from counselors' monthly reports, totaled for the year, and summarized for presentation in tabular form.

Clients served, as shown in Table 6, in the service and outreach modes, were predominantly under 18 years of age. Of that number, 57 percent were female. Among female clients under 18, 16 percent were pregnant or had given birth in the past. AAHEP served 8111 persons in "outreach" during the first year or approximately 900 persons per counselor. These clients were between 18-25 years of age.

TABLE 6
Numbers of Clients (12-25) Served by AAHEP Staff
October 1, 1982-September 30, 1983

	Younger than 18	Ages 18-25	Total
MOTHERS (non-pregnant, have given birth)	34	23	57
FATHERS (partner has given birth, not expecting)	3	9	12
PREGNANT MOTHERS (has child, expecting another)	3	16	21
EXPECTANT FATHERS (has child, expecting another)	3	6	9
PREGNANT FEMALES (expecting first child)	69	13	82
EXPECTANT MALES (expecting first child)	7	4	11
FEMALES (have not given birth, not expecting)	560	18	578
MALES (not a father, not "expecting")	428	21	449
TOTAL FEMALES	668	70	738
TOTAL MALES	441	40	481
TOTAL SERVED	1109	110	1219
TOTAL CONTACTED IN OUTREACH, <u>NOT</u> GIVEN OTHER SERVICE	6153	739	6892
TOTAL CONTACTED IN OUTREACH <u>AND</u> GIVEN OTHER SERVICE	7262	849	8111

Table 7 shows that 34 percent (N=1211) of other persons served by AAHEP were family members of adolescents. Twenty percent of the adults (N=703) were teachers of adolescents. The AAHEP staff reported serving approximately 3520 adults in 1982-83.

TABLE 7

Number of "Others" (Primarily Adults) Served by AAHEP Staff
October 1, 1982 - September 30, 1983

Mothers of Adolescents	612
Fathers of Adolescents	479
Members of Adolescents' Families	120
Teachers of Adolescents	703
Non-teacher Professionals Serving Adolescents	972
Other Professionals	296
Other Adults	338
Total Adults	3520

Data included in Table 8 show that the preponderance of service and outreach has been focused on persons 11 through 19 years of age. Nearly 59 percent of all AAHEP services and outreach were focused on the teenage and adolescent population. These data indicate that AAHEP staff served a total of approximately 11631 persons of all ages, or an average of 1292 persons per counselor (N=9).

TABLE 8

Number of Persons Served by AAHEP Staff By Age
October 1, 1982-September 30, 1983

<u>Age</u>	<u>Number</u>
0-1	68
2-5	28
6-10	23
11-15	2,971
16-17	3,403
18-19	429
20-25	581
Over 25	3,144
Unknown	984
Total	11,631

In Table 9, numbers of people served in each of the counties in the AAHEP area are shown. The figures indicate a wide disparity in numbers of people served from county to county. This is due in part to population differences among the counties. But, in a large measure, the differences reflect the level of effort expended in the 15 counties, often a factor of the location of the office of the counselor (9 counselors; 15 counties).

TABLE 9

Number of Persons Served by AAHEP Staff by County
October 1, 1982 - September 30, 1983

<u>County</u>	<u>N</u>	<u>County</u>	<u>N</u>
Anderson	3,392	Loudon	5
Blount	2,136	Monroe	26
Campbell	451	Morgan	233
Claiborne	326	Roane	400
Cocke	748	Scott	313
Grainger	140	Sevier	322
Hamblen	355	Union	185
Jefferson	2,005	Unknown	567
Knox	27		
Total		11,631	

Forty-six children were born to clients during the year. A small proportion, less than 10 percent, were placed for adoption. Of the 46 children born, 42 were kept by the mother and/or family (Table 10).

TABLE 10

Number of Infants Served by AAHEP Staff
October 1, 1982 - September 30, 1983

<u>Category</u>	<u>N</u>
Infants born to adolescents in project	35
Infants placed for adoption by adolescent in project	3
Infants born to young adults in project	11
Infants placed for adoption by young adults in project	1

Clients were referred to a variety of assistive agencies for services. There were approximately 337 referrals. Table 11 shows that medical assistance accounted for 42 percent of all referrals. Counseling of all types accounted for 36 percent of the referrals. These are referrals made when clients are unwilling or unable to contact agencies directly, and when clients are not already receiving services.

TABLE 11
Number of Referrals Made by AAHEP Staff
October 1, 1982 - September 30, 1983

<u>Category</u>	<u>N</u>
REFERRALS FOR MENTAL HEALTH COUNSELING	37
REFERRALS FOR ADOPTION COUNSELING AND SERVICE	18
REFERRALS FOR MEDICAL TREATMENT (primary and preventive)	96
REFERRALS FOR MEDICAL TEST (pregnancy and STD testing)	39
REFERRALS FOR RESIDENTIAL CARE OR MATERNITY HOME CARE	14
REFERRALS FOR MATERNITY, NUTRITION, OR DELIVERY COUNSELING	30
REFERRALS FOR EDUCATIONAL AND VOCATIONAL COUNSELING	35
REFERRALS FOR PEDIATRIC CARE	5
REFERRALS FOR MISCELLANEOUS SERVICES	63
Total	337

Figures (data) in Table 12 show that counseling of all types accounts for the majority of time staff members devoted to service delivery (approximately 67%). The other major block of time was devoted to outreach presentations and lectures (approximately 33%). These two activities, then, represent, in their several facets, the totality of services provided by staff.

The division of time described above closely parallels the division of numbers of activities pursued. Individual counseling sessions, some of which were home visits, were the single most frequent service provided. The proportional split between numbers of counseling and outreach services is closely parallel to the split in time (approximately 75% for counseling, 25% for outreach).

TABLE 12

Number of Services, Numbers of Persons Receiving Services, and
Hours Devoted to the Services by AAHEP Staff
October 1, 1982-September 30, 1983

<u>Services</u>	<u>Number</u>	<u>Number of Persons Attending</u>	<u>Hours by AAHEP Staff*</u>
Outreach Presentation	545	7403	944.5
Lectures	79	1117	237.5
Individual Counseling Sessions	775	254	1376
Group Counseling Sessions	150	99	297
Single Relationship Counseling Sessions	184	300	424.5
Relationship Group Sessions	6	12	47
Individual Initial Contact Sessions	207	207	289.5
Sessions Devoted to Supervision or Training of Volunteers	38	26	Included in above
Number of Persons Assisted by Volunteers or Donating Professionals	NA	109	NA
Home Visits	653	NA	Included in above
Special Events Attended (health fairs, etc.)	71	NA	Included in above
*Does not account for orientation, training, planning, setting up offices, relocation, etc.			

Table 13 indicates that the two activities which required the most time of staff members were administrative tasks and meetings and travel. The number of home visits made, shown in Table 12, required travel. The extent of the time required for travel to homes and for other purposes is evident from the figures in Table 13.

The diverse nature of AAHEP and the large geographical area it serves require not only travel, but also time for meetings to coordinate the work of the project. These two activities, travel and meeting time, which result directly from the nature of the project, its geographical setting, and the type of services provided are crucial to the operation of the project and represent a situation not encountered in more densely populated areas. Note that from October 1982 - September, 1983 AAHEP staff logged over 107,000 miles (and counselors did not start work until January, 1983).

TABLE 13

Number of Hours Devoted to Administrative Tasks and
Travel by AAHEP Staff
October 1, 1982-September 30, 1983

Activities	Number of Hours
Follow-up Activities	680
Travel	1739.5
Reports, Staff Meetings, and Staff Development	1850.5
Other	230

In addition to the information presented in Tables 6 through 13, four other sets of data are germane. First, the racial composition of the population served by AAHEP was 95 percent Caucasian, 4.8 percent Black, and .2 percent American Indian and Asian American. This distribution reflects the predominance of Caucasians in the region. A larger proportion of minorities would probably have been involved with the project if Knox County, the county in which the City of Knoxville is located, had been included among the AAHEP counties.

Thirty-three adolescents sought counseling during the year but could not be served because parental permission could not be obtained. By contrast, for 855 adolescents, parental permission was obtained. Although 33 out of 888 is not a large percentage (4 percent), it does represent a group of adolescents who might have benefited from project assistance, but could not be assisted.

In Table 11, it was shown that AAHEP staff members made 337 referrals during the year. Of equal importance is the number of times other agencies and individuals referred potential clients to AAHEP. Staff members received 242 referrals from professionals (school personnel, social workers, medical personnel). In addition, 17 parents or family members referred clients to the project.

The division of hours devoted by counselors to care and prevention was almost equal. Care activities accounted for 47 percent of all service time, and prevention accounted for 53 percent, according to counselor work logs.

V. DATA FROM COUNSELORS

Counselor Information

The counselors of AAHEP are the people who conduct the person-to-person activities that are the heart of AAHEP. They meet with the pregnant teens, they make presentations, they counsel, they staff the field offices and are in the communities and counties.

Data were collected from counselors (besides counselor data about clients and records of work) in three ways: a counselor questionnaire (see Appendix A); an impact statement written by each counselor describing that counselor's perception of impact of her/his work in each work area or county; and a group interview (10/14/83) with seven of the nine counselors. Data and responses from each of the three data sources are provided below.

Counselor Survey Summary. Each question from the counselor questionnaire is listed below with a summary of counselor (N=9) responses to that question. The response scale was 1 (not well) to 5 (very well).

1. What goals did you set for yourself for 1982-83?

To establish personal and agency credibility within the counties, to contact other community agencies, and to become established as a resource person for each community and for pregnant teenage girls.

2. How well, on a scale of 1 (not very well) to 5 (very well), do you think you met the goals which you set for yourself?

Average response: 4.1. Comments related primarily to the uncertainty of the project which prevented counselors from achieving goals to the fullest. (Late start, problems with information on continuation funding, some changing demands for data, etc.).

3. What specific goals are you setting for yourself in the next few months, for the next year?

Five of the nine counselors stated their uncertainty as to the future of the project and, therefore, were uncertain about forming goals for the future. However, they also spoke of the need to continue to provide the services which they had promised and to expand into different areas. Generally, counselors expressed a strong need to reach more teenagers and wanted to do this in a number of different ways: working with younger students in the middle schools, making teaching curriculum materials available to teachers, setting up peer counselors, working to train volunteers, and working with groups of students. Additionally, they stated that day care facilities for teenage mothers were needed so that these girls could finish their high school education.

4. Rate the project. On a scale of 1 (not very well) to 5 (very well), rate to what extent you feel the project is meeting its objectives. (a-g relate to AAHEP goals from the proposal.)

- a) To coordinate available prevention and care services to maximize the impact of existing programs.
Average response: 4. Comments were made that some counties were slow to use AAHEP services and that the health departments were not always cooperative.
- b) To make additional resource personnel available to adolescents and their families.
Average response: 4. Comments stated that counselors were busy locating resources which the teenagers could use and linking them together. The need for volunteers was mentioned.
- c) To generate the resources needed to continue AAHEP's services in the absence of federal funding.
Average response: 2. Comments were that first counselors must establish themselves, then later maybe they can locate resources. Also one counselor stated that legal restrictions prevented looking for other funding sources.
- d) To arrange appropriate services by adolescents regardless of their proximity to available services.
Average response: 4+. Comments: Much needed; the area served is so poor, large and rural, and there is no public transportation system established; transportation is difficult for these teenagers. AAHEP is the only agency which provides transportation to the home for the counselor and sees that the teenager gets pre- and post-natal care.
- e) To provide individual assistance to pregnant adolescents in making arrangements for their delivery.
Average response: 3.6. Comments: The counselors provide assistance not only concerning the physical arrangement but information to reduce anxiety and to educate teenagers as to what to expect.
- f) To provide more adequate education of adolescents related to sexuality including continuous availability of information.
Average response: 3.7. Comments: There was a range of response from "there is a good response from teenagers and teachers are using our resource materials in the classroom and demand exceeds possible implementation by one person" to "groups and agencies are slow to allow AAHEP access to some adolescents." One counselor was concerned to know if the prevention component will continue under the grant.
- g) To create a system for involving families and religious organizations in the education of adolescents related to sexual responsibility.
Average response: 3.3. Comments: The churches are accepting us. I am scheduled to do some parenting groups and teen awareness. Some resist us.
5. What things are, in your opinion, being done well? Specify.
Comprehensive care for pregnant teenagers, coordinating existing services and providing transportation were the three areas most often named. Prevention was named twice.

6. What things could use improvement? Include, if possible, specific suggestions.

Organization and clear communication of AAHEP administration was mentioned twice. The need to obtain additional help from volunteers or graduate assistants was also mentioned twice. Additional educational materials for teachers, periodic counselors training, better service coordination, day care, and development of parent and church sex education groups were mentioned one time each.

7. What are your perceptions about the reaction of other agencies to the project? (Give example.)

All of the counselors stated that other agencies about which they knew, although perhaps initially skeptical, had positive reactions to AAHEP now.

8. What are your perceptions about the general reaction of clients to the program? (Give example.)

"Generally positive, mostly good, pleasantly surprised, great reaction, relieved clients, generally open, mixed, reactions are varied, surprised and pleased."

9. What do you see are your biggest problems?

The following were each cited four times: uncertainty about project funding, travel, lack of time, lack of medical services in one area, demand exceeding ability to help.

10. What do you think you and the project do particularly well?

Comments included: networking, knowing the resources available, outreach for clients not usually found or helped, counseling individually.

11. What suggestions would you give the supervisory staff in order to help you, the project, etc.?

Four counselors cited the need for more and better inservice or training. Three counselors wanted more help with curriculum development. Two counselors wanted greater voice in AAHEP functioning, better communication and planning. Other counselors wanted: community agency involvement in the administration of AAHEP, help with personal frustrations, and money for travel expenses.

12. What suggestions would you give the administrative staff in order to help you, the project, etc.?

Comments included: better communication, counselor input into AAHEP, travel money, less forms. (These responses were in addition to the response in question #11.)

13. List agencies that you work with (PREVENTION) and rate the quality.

Schools: 45 (Quality: average 4)

Churches: 8 (Quality: average 4)

Community Agencies: 53 (Quality: average 4.4)

Counselor Group Interview. On 10/14/83 evaluators (4) met with 7 of the 9 AAHEP counselors. One goal of the meeting was to conduct a semi-structured and somewhat informal group interview to obtain their perceptions of aspects of AAHEP. The counselors are the field workers, or the staff. AAHEP is one of several projects in the Douglas-Cherokee Economic Authority (DCEA) and works within the structure and policies of DCEA. AAHEP has an administrative-training-coordinating staff of three: project director, associate director for education, and associate director for care. The nine counselors and support personnel complete the formal staff.

It was apparent that the counselors had concerns with management/administration, and especially as this was impacted by relationships with the funding agency (HSS). Much of this concern related to the late notice of funding (which caused each to receive letters of intent to terminate them as per DCEA policy) and the funding cuts which resulted in cuts in their travel budgets (note Table 13, p. 29 showing time spent in travel). The large area of AAHEP and transportation needs of clients are important determinants of the need for a substantial travel budget. The letters of intent to layoff came as a surprise to many, and some counselors were concerned about continuing to make and keep promises to their clients.

Counselors do not know how long they will be serving these clients (uncertainty) and are hesitant to make commitments. It is difficult to set up priorities when you do not know if the program will be funded. "We just spent a year establishing trust, contacts, believability." "The layoff letters really affected morale." "There is a need to establish the budget earlier." (Quotes are comments of counselors.)

The counselors questioned the administration's lack of involving them and providing early, clear communications about the funding situation. They were unclear about any administration efforts to refocus the project and/or cut services to some counties (this was cleared up at a later meeting and by a memo).

Confusion was expressed about next year's goals. "Are we going to be asked to move into Knox County?" "Will only some of us be offering prevention? Care? Can the two be separated?" "We want to give professional quality services." "This year there has been an arbitrary separation of care and prevention and concern for individuals. Where was this

decision made? Washington?" "This year the goals seemed very ambiguous." "Is this a demonstration project, or a statistical impact project?" "These goals are quite different and it seems that in midstream we have taken on a new direction. Washington approved the project as it was written." "Is Washington not under legal obligation to carry out our grant?" (These last statements were made concerning some changes in the requirements for reporting of project data for administrative records and for evaluation.)

One AAHEP goal is to reduce teenage pregnancy. "How can you reduce teenage pregnancy, if you cut out prevention?"

This is a rural project, but transportation is cut. "Is this coming from Washington or AAHEP? The highest pregnancy rates are in Scott, Cocke, Grainger, Roane, and Morgan counties. They are the most rural counties. Why cut transportation?" "For many of our clients, telephones and communication are not available. In order to get them a message you have to drive it to them. Washington does not seem to understand this."

Counselors were not aware of re-funding of the project until today (10/19/83), several weeks after the layoff letter. They were not aware of the initial notice to re-fund the project at the \$175,000 to \$200,000 level, and the resulting effort and negotiations of AAHEP administration to increase that budget to the \$300,000 range.

Counselors expressed some concern over "panic situation--do it NOW." They expressed concerns over lines and clarity of some communications. They were concerned about repeated requests for data and the need to document "in-kind" for the project. They commented on some inconsistencies in information about what data were needed so a client could get Medicaid. "I have problems with the ethics of giving client names to Nashville without client or parent permission." (AAHEP then actually documented the number of clients without using names.) Confidentiality is a key concern. Counselors perceived that changing personnel in Washington and changing requests from Washington caused disruptions in the normal administrative flow and pattern at AAHEP.

Counselors believe that they should have more involvement in project administration and planning. In response to the question, "Did you have input to the resubmission of the proposal?"--"No. When was it resubmitted?" Counselors believe that they could have suggested some possible approaches and alternatives. They say that they would like more involvement. The

counselors also asked about the logic and use of the "overhead" that goes to DCEA. They wondered why this money could not be used directly by the project staff. (This was explained.)

In summary, when asked the question, "Would you say that counselors are concerned about project management and direction and about communication (clarity, lines, tone)?" all seven counselors at the group interview agreed.

Counselor Impact Statements. As part of the AAHEP project evaluation the AAHEP counselors were asked to write impact statements summarizing how they and AAHEP had influenced their counties for the first year. Nine impact statements resulted. The following is a summary of these responses.

Awareness and knowledge of the community of the project were slow at first as the counselors contacted newspapers, schools, community agencies and leaders and prepared information brochures for dissemination. As the counselors became known as persons and as they established permanent offices within the counties, they and AAHEP became accepted in most communities. Referrals began to come in from individuals seeing the brochures, from schools requesting counselors' services for their teachers and in their classrooms, and from community agencies and personnel.

Counselors were requested to do workshops and inservice presentations to teachers. They did classroom presentations via lecture, pictures and discussions in Biology, Family Life, Health Education, and Home Economics classes. Resource lists and materials were made available to teachers and other personnel for use with groups.

Presentations were made to many groups and agencies: Kiwanis, Lions, ministers, Appalachian Regional Commission, American Association of University Women, interagency groups, Department of Human Service workers, Department of Health and Environment personnel, nurses' conventions, doctors' groups, mental health organizations, hospital social workers, maternity home personnel, adoption agency counselors, mayors, councilmen, school superintendents, principals, county commissioners, churches, chambers of commerce personnel, and at health and county fairs.

Referrals for service have resulted. Counselors have been asked to provide a complete range of services from clothing, health, financial and rental assistance to transportation and emotional support. Services have also included home tutoring and help in obtaining birth certificates and

social security cards. Services are also provided to many teen partners and families. AAHEP has also been used as an information and referral link to other agencies. Referrals have been from students, drop outs, teenagers experiencing pregnancy scares, teenagers seeking information, victims of abuse and incest as well as students just needing to talk about their concerns about themselves, dating or sexuality. The rate of referrals to counselors has increased considerably. One counselor reports 6 new ones a day at one school alone; another cites 40% increase in referrals in one month, September.

Counselors report that the need for their services exceeds their current ability to keep up. One cited 15 schools in her area for which she was attempting to schedule some service; others cited doctors or community groups who wanted them but whom they were unable to see yet. Counselors have been told by professionals and clients that they fill the gap between the service provider and the clients in the community. Teenagers' comments have also been positive ranging from "You really understand what kind of information we teens need" and "We appreciate the time you take for this" to "Nobody ever cared enough to do this" and "My parents are good, but I can't talk to them about things that matter to me."

Counselors state that it may be easier to see impact by looking at the individual than by looking at the communities as a whole. It can clearly be seen that numerous people have been contacted by AAHEP outreach efforts; however, a judgment on quality of services clearly rests upon the care clients receive. As one counselor put it, whether or not a client is pregnant upon referral, "the clients' knowledge and respect for their bodies have increased, enabling them to become more responsible decision-makers in the care and use of their bodies."

VI. DATA FROM PRE-NATAL REFERRAL GROUP

Introduction

During the first year of AAHEP's functioning the program counselors have received referrals and provided care for 35 pregnant teenage girls who all delivered prior to September 30, 1983. Data about these 35 teenage mothers, or clients, were obtained from the nine project counselors using a form designed for this project evaluation. (See Appendix B.) Care was taken that clients confidentiality was respected; names were disguised, abbreviated or coded by the counselors prior to their returning the forms to the project evaluation staff, so that at no time could evaluation staff identify any of the data with the clients. What follows is a description and analysis of the data received from the counselors concerning their 35 clients (the pre-natal referral group).

Trimester and Source of Referral

The evaluation team first examined the time of the referral of the pregnant teenager and divided the data into trimester of pregnancy in which the referral occurred. Of the 35 clients only 5 (or 14 percent) were referred during the first trimester of pregnancy. (See Table 14.) Most of the clients, N=17, were referred to AAHEP during the second trimester of pregnancy; this was 49 percent or almost half of the total number of referrals. There was a sizeable group of 13, 37 percent of the client population, who were not referred to AAHEP until the third trimester of pregnancy.

TABLE 14
Trimester of Referral of AAHEP Clients

<u>Months</u>	<u>Trimester</u>	<u>N</u>	<u>Approximate Percentage</u>
Months 0-3	1st	5	14
Months 3-6	2nd	17	49
Months 6-9	3rd	13	37
Total		35	100

The source of the client referral was also examined. (See Table 15.) Sixteen clients, 46 percent of the referrals, came from schools. The

source of 9 referrals was unknown, while the next largest referral source was the Tennessee Department of Health and Environment with 5; this includes 2 referrals from the Department of Child Health and Development. These two sources accounted for approximately 14 percent of the referrals. Other sources of referral with one each were Child and Family Services, Human Services, the hospital, self, and the family.

TABLE 15
Referrals to AAHEP

<u>Source of Referral</u>	<u>N</u>	<u>Approximate Percentage</u>
School	16	46
Unknown	9	26
Dept. of Health & Environment	5	14
Child & Family Services	1	3
Human Services	1	3
Hospital	1	3
Self	1	3
Family	1	3
Total number of referrals	35	101*
*Rounding error		

AAHEP Services

After each referral was received, the counselors met with the client, determined her needs and prepared a care plan individually tailored to her needs. This plan included services which might be given by the AAHEP counselor as well as referrals for service to other agencies. AAHEP services could include personal counseling, information and counseling on nutrition and hygiene, family counseling, vocational and education counseling, parent-ing education, family planning, adoption counseling, child care information, help with housing problems and consumer education, aid in arrangements for the delivery of the baby, financial counseling, and group counseling with peers with similar problems and concerns.

Table 16 shows that personal counseling heads the list of the most frequently used services. Individual counseling was provided to 34 clients, 97 percent of the cases. This was followed next in frequency by counseling and information on nutrition and health with 18, 51 percent, of the clients receiving this service. Family counseling or help for the client's immediate family was also provided for 17, 49 percent, of the clients.

Vocational and/or education counseling was provided for 16, 46 percent, of the clients.

TABLE 16

AAHEP Services: Types and Number of Services Provided with Percentage

AAHEP Services Provided	N	Percent of Clients (N=35)
		Receiving the Service*
Personal Counseling	34	97
Nutrition and Hygiene	18	51
Family Counseling	17	49
Vocational or Educational Counseling	16	46
Parenting Education	12	34
Family Planning	8	23
Adoption	8	23
Child Care	8	23
Housing/Consumer	7	20
Delivery Arrangements	6	17
Financial Counseling	5	14
Group Counseling	3	9
Total	142	

*Some clients received more than one service.

Parenting education was requested by 12 clients, 34 percent, of the population. Next in frequency were three services: family planning information, adoption counseling, and child care information; each was requested by and given to 8 clients, 23 percent, of the total client population. Housing problems and consumer education services were provided to 7 clients, 20 percent. Help with child delivery arrangements was given to 6 clients. Counseling concerning financial planning and budgeting was requested and given to 5 clients, and group counseling with peers was arranged for 3 clients.

To summarize, 12 different types of services were offered and given to clients by AAHEP counselors with a total of 142 service units provided to the 35 clients. This is an average of 4 services per client and 11.8 clients for each service.

Examination of the frequency of request for certain types of services provides an indication of the priority or importance of the client's needs. It would seem that the most pressing or most important need would be the one requested by the most clients and given most frequently by the AAHEP

counselors. Viewing the data this way, the basic need of personal counseling or help with the emotional aspects of being a pregnant teenage girl was most important and most requested. Having someone to talk with, who can listen, as well as respond with emotional support and information seems to have been most highly valued.

Help with personal care, nutrition and hygiene seems to have been the next highest priority. After some basic emotional concerns are met, attention can then be turned toward the present with the physical care of the mother and child taking precedence.

Family counseling as a way to provide a base of support to the client during and after the course of her pregnancy and delivery is the next most frequently used AAHEP service. This service not only helps the family, but extends the support which the counselor provides to the client's immediate environment.

Vocational and/or educational counseling is the fourth most frequently used AAHEP service. The clients are concerned about their future and see education as important to that future.

Parenting education (learning how to be a parent and how to relate to a child as a person with needs) is a future-oriented skill. A sizeable portion of clients requested this sort of assistance. Family planning, adoption counseling, and child care are also future-oriented topics which help clients plan what to do when the baby arrives. The decision to keep the child, how to care for it, and whether she will in the future have another child were important topics for about one-fourth of the client population.

Other topics such as housing and consumer education, delivery arrangements, financial counseling and group counseling are of lesser importance based on the low frequency of requests for services in these areas.

AAHEP Referrals to Other Agencies

AAHEP counselors also make referrals to other agencies for services for their clients. (See Table 17.) Most referrals were to the Health Department pre-natal care, applications to the Women, Infants, and Children (WIC) Project which gives vouchers for food as well as nutrition counseling, and screening and treatment of venereal disease. Thirteen clients were referred to the Department of Public Health and Environment. Ten received WIC aid, two received injections, and three participated in classes on nutrition.

TABLE 17

AAHEP Referrals (Prenatal Group) to Other Agencies and Results (if known)

Agency	Results	N	Percent of Clients (N=35)
			Receiving this Service*
Dept. of Public Health and Environment	WIC (10)	13	37
	Shots (2)		6
	Classes (3)		9
Department of Human Services		13	37
	AFDC (5)		14
	Medicaid (12)		34
Doctor	Pre-natal care	10	29
	Pre-natal care	3	9
Clinic		3	9
Client initiated services		3	9
Social Security	Social Security	2	6
Housing	Waiting list	2	6
Hospital		1	3
Maternity Home		1	3
Board of Education		1	3
Red Cross	Pre-delivery class	1	3
AEOC		1	3
Church	Clothes	1	3
Goodwill	Clothes & bed	1	3
Legal Services		1	3
Protective Services		1	3
Total		55	

*Some clients received more than one service.

The Department of Human Services also received 13 referrals from AAHEP. Five clients received AFDC and 12 received Medicaid. Ten clients were referred to local doctors for pre-natal care. Each of these two government agencies saw 37 percent of the AAHEP clientele. The services given were of a high priority--pre-natal health care, food, and financial assistance for living and medical expenses. Other services which were sought by referrals from AAHEP were social security, housing, hospital care, and placement in a maternity home.

Education was also a reason for referral. A number of clients sought aid from a Board of Education, the Red Cross for a pre-natal class, and the Appalachian Education Opportunity Center for job training and educational information. Clothing was sought from church and Goodwill sources. Legal and protective services were also reasons for referral. Again, the priority and frequency of types of service sought indicate that after basic concerns of food, financial and health care, a secondary set of service--education, clothing, and security--was sought.

The total number of referrals made by AAHEP to other agencies was 55. Sixteen different agencies were used to receive clients. Each client averaged 1.5 referrals in the pre-natal referral group (N=35).

These service were provided for the most part during the second and third trimester of client pregnancy. (See Table 18.) Only 20 percent of the service were provided during the first trimester of pregnancy. However, over half of the clients or 57 percent were served during the first and second trimesters, and the dates of initial service were unknown for 11 percent of the group.

TABLE 18
Initial Trimester when Services were Provided
When Were the Services Provided?

<u>Trimester</u>	<u>N</u>	<u>%</u>
1st	7	20
2nd	13	37
3rd	11	31
Unknown	4	11
Total	35	99*
*Rounding error		

Data about a client's initial contact with a primary health provider, either a doctor or a health clinic, appear in Table 19. Although the time of the initial contact with health care providers is not known for 12, 34 percent, of the clients, about half, 17, or 49 percent, of them were seen during the first and second trimesters of pregnancy.

TABLE 19
Initial Doctor or Health Department Visit

<u>Trimester</u>	<u>N</u>	<u>%</u>
1st	7	20
2nd	10	29
3rd	6	17
Unknown	12	34
Total	35	100

Data were collected relative to the living arrangements of the teen parent and child. The largest number, 13, or 37 percent, live with the teen mother's immediate family. (See Table 20.) This is followed in frequency by 7, 20 percent, who live with the father of the child. Another 25 percent (N=9) live with the child's father and either the immediate or extended family. Thus a total of 46 percent live with the father of the child in one living arrangement or another. Data indicate that in 83 percent of the cases both the child and the mother are getting some support from the family environments and are not entirely on their own.

TABLE 20
Living Arrangements: Teen Parent/Child

<u>Location</u>	<u>N</u>	<u>%</u>
With immediate family	13	37
With father of child	7	20
With father of child and immediate family	5	14
With father of child and extended family	4	11
Alone without child	1	3
Alone with child	2	6
Foster parents	1	3
Various	1	3
Unkknown	1	3
Total	35	100

After birth, AAHEP continued to offer services to the teenage mothers and their children. Eleven different services were offered to the 35 clients and their children. (See Table 21.) Personal counseling was the most frequently provided service, which was most used by 15, 43 percent, of the cases. Child care and family planning information came next in frequency of use (25 and 22 percent of the clients requesting them). These were followed by educational information and family counseling with several referrals each. This seems to substantiate the earlier observation that the first priority for service is emotional and informational support; the practical aspects of child care and birth control seem to be second in importance. After the child's birth it seems that the clients have less need of AAHEP services or perhaps there has just been less time to make use of them so far. Currently the use of AAHEP services post-natally has averaged 1.5 services per client as compared to 4.0 services used pre-natally (post-natal services to pre-natal referral group).

TABLE 21
AAHEP Post-Natal Services Provided

<u>Service</u>	<u>N</u>	<u>Percentage of Clients (N=35)</u> <u>Receiving This Service*</u>	
Counseling	15	43	
Child Care	9	25	
Family Planning	8	22	*Some clients received more than one service.
Educational information	5	14	
Family Counseling	4	11	
Post-natal health visits	3	9	
Parenting Group	3	9	
Adoption Counseling	2	6	
Nutrition	2	6	
Housing	1	3	
Parenting Education	1	3	
Total	53	146*	

Post-natal referrals from AAHEP show somewhat of the same pattern as pre-natal referrals. (See Table 22.) Although the Department of Human Services and the Tennessee Department of Health and Environment receive a sizeable number of clients, within the Department of Health and Environment specifically, the Child Health and Development section gets the most referrals - the child care classes to which 8 clients were referred. The average number of services per client has dropped to just less than one (.91).

TABLE 22
Post-Natal Referrals of AAHEP Clients

<u>Agency or Location/Service</u> <u>(N=35)</u>	<u>N</u>	<u>Percentage of Clients</u> <u>Receiving the Service</u>	
Dept. of Health & Environment	14	40	
received CHD	8	22	
WIC	3	9	
Baby shots	2	6	
Dental	1	3	*Some clients received more than one service
Department of Human Services	5	14	
received Medicaid	2	6	
Birthright	2	6	
School	1	3	
Doctor	1	3	
Adoption	1	3	
Parents without Partners	1	3	
AEOC	1	3	
Juvenile Officer	1	3	
Homemaker	1	3	
Child Evaluation Program	1	3	
MDRC			
Sheltered Workshop	1	3	
Protective Services	1	3	
Housing	1	3	
Total	32	132*	

Providing services to clients regardless of their proximity to care facilities is one of AAHEP's objectives. Since public transportation is nonexistent, many of the clients are too young to drive legally, some clients do not have access to an automobile at times when a car is needed, and due to the remoteness of some of the houses of clients, it was necessary for AAHEP counselors to provide transportation.

According to the data, transportation was provided for a least 20 clients, most on more than one occasion. Numerous other times the counselor had to make home visits to see the client as the client had no means of transportation. Due to the conditions described above, teen mothers tend to be somewhat housebound with a newborn baby. In one case, the new mother depended upon the AAHEP counselor to take her to the hospital to see her baby in the intensive care unit.

AAHEP counselors were available to help the teen father. Most frequently they were called upon as counselors who could provide support to the teen father in his new role. Educational information was next most frequently requested. Four of the fathers expressed the desire to continue their education in order to prepare more adequately for the future. Some wanted to know about college, financial aid, admissions requirements, etc. Job hunting was also a concern, particularly as these teen fathers hoped to support their new family. (See Table 23.)

TABLE 23

AAHEP Services to Teen Father

<u>Services</u>	<u>N</u>	<u>%</u>
Counseling	10	29
None	9	26
Father Unknown	8	23
Info. about education	4	11
Job hunting	2	6
Family planning	1	3
Consumer info.	1	3
Total	35	101*
*Rounding error		

Services to the teen mother's family were also offered by AAHEP. Thirty-eight service were offered to 35 families, or an average of just

over one service per family. Counseling was the most frequently requested service with referrals to the Department of Health and Environment (for WIC and immunizations) coming next in frequency. (See Table 24.)

TABLE 24

AAHEP Services Provided to Teen's Family

<u>Services</u>	<u>N</u>	<u>%</u>
Counseling	16	46
Dept. of Public Health Referral	9	26
Dept. of Human Services Referral	4	11
Family planning	2	6
Adoption info.	2	6
Community Action Council (CAC)	2	6
Child care	1	3
Clothes	1	3
Head Start Referral	1	3
Total	38	

*Some clients received more than one service.

To follow up on the clients and look to the future, it is important to know what the clients are doing now. Over half of them are staying at home with their children. Twenty-two percent are in school and 6 percent are looking for jobs. (See Table 25.)

TABLE 25

What is Teen Parent Doing Now?

<u>Activity</u>	<u>N</u>	<u>%</u>
Staying at home with the child	19	54
Going to school	8	22
Unknown	5	14
Looking for a job	2	6
Living without child alone	1	3
Total	35	99*

*Rounding error

VII. DATA FROM POST-NATAL REFERRAL GROUP

Prior to September 30, 1983, AAHEP counselors received referrals for service to teenage clients who had already delivered their babies. These were termed post-natal referrals and constitute the post-natal referral group. Data were gathered and analyzed for 20 of these teenage mothers so that their relationship with AAHEP could be examined.

Table 26 shows that the source of the referral to AAHEP is not known for the largest number of clients, 7 or 35 percent. The most frequent source was St. Mary's Hospital which referred 4 or 20 percent of the post-natal clients. Schools referred 3 clients or 15 percent. There were 2 self referrals, 10 percent, and the Department of Human Services also referred 2 clients, 10 percent. Douglas Cherokee made one referral, 5 percent.

TABLE 26
Referral Sources of AAHEP Clients

<u>Source</u>	<u>N</u>	<u>%</u>
Unknown	7	35
St. Mary's Hospital	4	20
School	3	15
Self	2	15
Dept. of Human Services	2	10
Dept. of Public Health	1	5
Douglas Cherokee	1	5
Total	20	100

Table 27 shows that 11 clients, 55 percent of the teen parents, live with their immediate families. Five or 25 percent are living with the baby's father, and 2 or 10 percent are living with the baby's father and other family. The categories of "other" and "alone" each include one client or 5 percent of the population. These data show that 17, or 90 percent of the clients, are living in a potentially supportive environment and that 7 (35 percent) teen parents live with the baby's father.

TABLE 27

Living Arrangements: Teen Parents/Child

<u>Location</u>	<u>N</u>	<u>%</u>
with immediate family	11	55
with father of child	5	25
with father of child and family	2	10
alone without child	1	5
other	1	5
Total	20	100

Birth weights of the post-natal newborns were also noted. (See Table 28.) Although the weights at birth of 6 (30 percent) of the babies were unknown, it was known that 2 of the babies, 10 percent, had birth weights of less than 5.5 pounds.

TABLE 28

Birth Weight of AAHEP Clients' Babies

<u>5.5 pounds or less</u>	<u>N</u>	<u>%</u>
No	12	60
Unknown	6	30
Yes	2	10

AAHEP provided thirteen different services to these post-natal clients. Counseling accounted for 19, 95 percent, of the clients receiving emotional support. (See Table 29.) Educational or vocational counseling was the next priority for these clients as 11 clients, or 55 percent, requested this service from the AAHEP counselors. Parenting education and child care counseling, immediate concerns for post-natal clients, received 8 request each, or 40 percent of the total population for each service. Parenting groups had 4 client participants or 20 percent of the post-natal group. Housing concerns, family planning information, and concerns with nutrition and hygiene each received three referrals. These primarily health-related services were each requested by 15 percent of the client population. Adoption counseling and day care information each received one referral, or 5 percent of clients. Dating and financial concerns also each had one referral for 5 percent each of the population. These areas of concern held the lowest priority for teenage parents.

TABLE 29

AAHEP Post-Natal Services Provided

<u>Service</u>	<u>N</u>	<u>%</u>
Counseling	19	95
Educational/Vocational	11	55
Parenting education	8	40
Child care	8	40
Parenting group	4	20
Housing	3	15
Family planning	3	15
Nutrition	3	15
Hygiene	3	15
Adoption	1	5
Dating counseling	1	5
Day care	1	5
Financial	1	5
Total	66	

To summarize, 13 different services were given by AAHEP 66 times to the 20 post-natal clients. This averages to be approximately 3 services per client.

Referrals to other agencies were necessary for post-natal clients and are tabulated in Table 30. The Department of Human Services received 9 referrals, 45 percent of the client population. The Tennessee Department of Health and Environment also received referrals from 45 percent of the client population or 9 clients. These referrals were for a number of different services: family planning (5); WIC (2); health care treatment (1); and child health and development (1).

TABLE 30

Post-Natal Referrals of AAHEP Clients (N=20)

<u>Agency/Service</u>	<u>N</u>	<u>% of Clients Receiving Service*</u>	
Department of Human Services	9	45	
Received Medicaid (3)			
AFDC (3)			
Dept. of Public Health	8	40	*Some clients received more than one service.
Received family planning (5)			
Medical treatment (1)			
WIC (1)			
CHD (1)			
Appalachian Educational Opportunity Center	3	15	
Department of Employment Security	2	10	
Agricultural & Extension Service	1	5	
Douglas Cherokee Economic Assistance (rental)	1 -	5	
Total	24	*	

The Appalachian Education Opportunity Center (AEOC) received 3 referrals, 15 percent of the population. This resource provided counseling for education. Another resource for referrals and counseling concerning education and jobs was the Department of Employment Security which received referrals from 10 percent of the population, 2 referrals. The Agricultural and Extension Service received one referral for service as did the Douglas Cherokee Economic Assistance Project. These referrals each represent 5 percent of the client population. There were 6 agencies which received post-natal referrals from AAHEP. These agencies received a total of 24 referrals from 20 clients or just over one referral per client.

AAHEP counselor responses indicated that transportation to different agencies was provided for at least 5 clients (20 percent) of the client population. This figure does not reflect the number of times counselors had to make home visits to see the homebound clients.

AAHEP offered services to teen fathers. Among the 20 post-natal clients, two or 10 percent of the fathers received counseling, one to help find employment (5 percent) and one for emotional support (5 percent).

Services were provided to the teen's families. Support and counseling for the teen's mother were given in 4 cases. This was 20 percent of the population. Anecdotal notes from the client information form stated that for several of these cases counseling was necessary because of considerable emotional problems. Job counseling, a referral for supplementary security income (SSI) and nutrition counseling were also provided to client families. Five percent of the population was served for each of these services.

Table 31 indicates the teen parents' current vocational status. Nine clients (45 percent) are at home with their babies, while it is unknown what 2 clients are doing. Three clients are working at least part-time while one is looking for a job; this represents a total of 20 percent of the population. Another 20 percent (4 clients) are in school (2), studying for the GED (1), or considering college (1). One client (5 percent) dropped out of school.

TABLE 31

What is the Teen Parent Doing Now?

<u>Activity</u>	<u>N</u>	<u>%</u>
Home with the baby	9	45
Unknown	2	10
Working part-time	2	10
Working full-time	1	5
Looking for a job	1	5
In school	1	5
Studying for the GED	1	5
Considering college	1	5
Dropped out of school	1	5
Total	20	100

VIII. COMPARISON OF PRE AND POST-NATAL REFERRAL GROUP DATA

After presenting and summarizing data for 35 pre-natal referrals and 20 post-natal referrals, it seems appropriate to develop sets and a comparison of data to look for trends. The term post-natal refers to the post-natal referral group (N=20). These people were not seen by AAHEP until after delivery. Almost half (46 percent) of AAHEP pre-natal referrals (N=35) came from schools, while only 15 percent of the post-natal referrals came from this source. This may be because teenage mothers with babies tend not to be in school and therefore do not have them as information or referral source.

Although the source of referral is unknown for a large percentage of each group (26 percent pre-natal and 35 percent post-natal), the percentages of referrals from other agencies are rather close--23 percent for the pre-natal and 20 percent for the post-natal referral groups.

Analysis of current teen living arrangements shows that fewer (37 vs. 55 percent) of the pre-natal vs. post-natal referral group teens are living with their immediate families, while a large percentage (45 vs. 35 percent) of the pre-natal vs. post-natal referral-group teens are living with the child's father and/or some family. Overall, however, the percent of teens living with someone else (90 percent) is about the same for both groups.

Looking next at low birth weight of babies, 5.7 percent or 2 of the pre-natal group and 10 percent or 2 of the post-natal group had babies whose birth weight was less than 5.5 pounds. Note that one pre-natal group low-weight baby was an AAHEP referral just one week prior to delivery. This relationship should be examined in the future for possible trends.

Focusing on AAHEP services provided after childbirth, it can readily be seen that while the types of services provided to the pre- and post-natal groups were about the same, the quantity of services differed. The post-natal referral group, not having the advantage of prior AAHEP services, required an average of just over 3 services per client, while the pre-natal average was 1.5 services required. This reflects the previous provision of an average of 4 services to the pre-natal group. Personal counseling was requested and provided considerably more (95 vs. 43 percent) for the post-natal referral group than for the pre-natal group. Also for the

post-natal group, educational/vocational counseling was provided more frequently (55 vs. 14 percent) as was parenting education and child care (100 vs. 36 percent). For the areas of counseling, education, and child care, the needs of the post-natal referral group were greater than those of the pre-natal group.

A comparison of the post-natal referrals of AAHEP clients for the pre- and post-natal referrals groups shows that although the need for the service of the Department of Health and Environment is the same (40 percent) for the two groups, the need for the services of the Department of Human Services is greatly increased in the post-natal referral group (14 vs. 40 percent of the cases). Additionally, in 25 percent of the cases the post-natal group needed services from some other government agency but only 3 percent of the pre-natal group did.

A comparison of what the teen parent is doing now shows that after delivery 54 percent vs. 45 percent of the pre- vs. post-natal referral group teens were at home with their children. About the same percentage of teenage parents are in school (22 vs. 15 percent, pre- vs. post-natal referral groups), but there is a difference in the percentage of teen parents at work (0 vs. 15, pre- vs. post-natal referral groups).

IX. INTERVIEW SUMMARY: DELIVERED MOTHERS (N=4)

Data are summarized by the questions asked. No individuals are identified by name.

1. How did you learn about this counselor?

Three of the clients interviewed were pre-natal referrals and in each of these cases the referrals came from the schools, in two instances from a guidance counselor, and in one instance from an interested teacher. Also, one client had learned of AAHEP from an area hospital (Blount Memorial). The fourth client interviewed was a post-natal self referral. She had heard of AAHEP from friends and from a pamphlet in the health department and called Douglas Cherokee. From this small sample it is clear that school referrals have been critical for AAHEP in learning about girls who need services.

2. What did the counselor do for you?

Three of the interviewees prominently mentioned counseling as an important function of the counselor. This included both the giving of information (concerning WIC, health department services, school procedures, Medicaid, etc.) as well as personal counseling. Transportation for medical care was also mentioned by two respondents. In two cases the counselor acted as a liaison in making school arrangements. Hospital arrangements were also mentioned by two respondents, and in one case the counselor helped the teen parent's mother look for an apartment. It is clear that the counselors are actively involved in providing a wide range of services, from personal counseling to transportation. The "making of arrangements" both for continued schooling as well as for medical care at delivery seems particularly important.

3. What would you have done without this counselor?

Although three clients responded initially to this question with an "I don't know" and one said she would have cried, it was clear upon further elaboration that all four would have felt much more isolated without the counselors' help. All mentioned that they would not have known about available services and would not have been through the experience as successfully. Transportation for medical care was mentioned by two respondents as well as the encouragement to breastfeed and eventually continue schooling. Family help was mentioned by one respondent, and one felt that group interaction with other pregnant adolescents was very helpful. Again, the range of AAHEP services is apparent in the responses to this question. Also, the critical importance of the counselor/client relationship is highlighted by these responses.

4. What helped you the most?

Emotional support was mentioned as the most helpful by all four clients. Help with school problems figured prominently in two responses, and one again mentioned her participation in a support group. It is clear that the critical factors in these responses are again the counselor/client relationship and the implicit emotional support for the teen parent as well as the technical help in making arrangements and providing transportation.

5. What do you still need?

Two respondents mentioned that they still need help making child care arrangements so they can continue schooling. Also, three mentioned that they still need emotional support, and one still needs transportation to the doctor. These answers illustrate the importance of continuing AAHEP services following the delivery of the babies.

6. Did the counselor talk with the baby's father? How often? How did he feel about it?

Two of the clients answered that the counselor had talked to the fathers of the babies. In one of the other two cases there was a peace warrant issued to the father, and in the other the client did not want the counselor to work with the baby's father. The interactions with the two teen fathers that did see the counselors appear to have been extensive and supportive. In one case the counselor is male and the teen father stated that at first he was jealous but that he soon realized that the counselor was a warm, supportive, and helpful friend. It is interesting to note that in half these cases the counselor was able to establish a relationship with the babies' fathers and that in these cases the relationships appear to be helpful to both teens.

7. Did your parents talk to the counselor? How often? How did they feel about it?

In three out of the four situations the counselors' involvement with the teens' mothers appeared to be quite extensive. And, in two of these cases the teens' fathers also appeared to have interactions with the respective counselors. In the fourth case the counselor did talk to the girl's mother twice, one of these times at the hospital while the girl was in delivery. Again, in the three cases where extensive involvement occurred the counselors provided both emotional support through listening and caring and technical assistance through the sharing of information. The responses to this question and the previous one serve to illustrate the rather extensive apparent involvement of AAHEP's counselors with the extended families of their clients.

8. What are you thinking about for your immediate future plans? For the baby? For yourself?

Of the four clients interviewed, two are currently in school and two are making plans to return in the very near future. Three expressed desires to "raise the baby right," and three have definite vocational plans (secretarial, cosmetology, and nursing). One is trying to find better housing. All seemed reasonably clear and realistic about their goals. AAHEP counselors appear to have been helpful in this process, particularly in encouraging the client to finish school and in helping to make the necessary arrangements both for child care and with the schools.

9. What other people (agencies) are helping you now? Did the AAHEP counselor help you get in touch with them? What are they doing for you? How good do you believe this help is?

Three of the interviewees are on WIC, two are receiving Medicaid, one is on AFDC, one is still receiving health department services, one is receiving food stamps, and one is still participating in a

support group with other teen mothers. In almost all of these cases the counselors were instrumental in helping the clients apply for these services.

10. How would you rate the services you received from AAHEP?

In all four cases the respondents rated their respective counselors at the very top of the scales, and it was clear that each counselor/client relationship was very strong and critically important to each girl. Each still felt a need for a continuing relationship with her counselor. Emotional support is still needed, as well as technical support in applying for needed services. Transportation is still important for at least two of the girls. "We couldn't have made it without him" seems to sum up the importance of the AAHEP counselor in each of these girls' lives.

X. INTERVIEW SUMMARIES: HEALTH CARE PROVIDERS

Four interviews were conducted with health care providers. Three of these were in doctors' offices (2 nurses, one receptionist) and one was with a health department nurse.

1. Did you discern any difference in AAHEP teen clients from other non-AAHEP pregnant teens? Examples?

While the health department nurse stated "No" without elaboration and one of the respondents from a doctor's office was unable to make a distinction between AAHEP teens and non-AAHEP teens, the other two respondents saw the counseling and technical assistance provided by AAHEP as making a critical difference for girls going through the experience of a teenage pregnancy. One stated that the girls associated with AAHEP were more relaxed, were less scared, and had less complicated deliveries. The other respondent felt that the counseling provided by AAHEP was very important before and after delivery. Two respondents mentioned the newness of AAHEP and reserved any definitive comments until more interaction with the project had taken place.

2. What benefit do you believe that these clients derive from involvement in AAHEP?

Transportation was mentioned by two respondents, and two mentioned the help clients received in applying for and receiving services for which they were eligible. Counseling support and the providing of more options were also mentioned by two of the respondents. One mentioned again that the delivery was easier and that the counselor was able to provide follow-up which the doctor's office was not equipped to do. All felt that AAHEP had provided real help and had served to expand the girls' choices in addition to all the technical assistance provided.

3. What services or information could/should AAHEP provide to improve its services (e.g., to prepare clients better for delivery)?

Only one interviewee chose to respond to this question. He suggested that prenatal classes be encouraged as well as more counseling. Caution was also expressed that AAHEP counselors not spread themselves too thin in order to provide more focused and concentrated help for each client.

4. What procedures should AAHEP institute that would enable your agency to act more effectively with such clients?

Three out of the four interviewees responded to this question. Two stated that they felt they already had very good working relationships with AAHEP counselors. One suggested a meeting be scheduled with representatives from all the schools, the AAHEP counselor, and health care providers in order to coordinate service delivery more effectively. Another suggestion mentioned was a better referral system. The interviewees not only are appreciative of the work that AAHEP counselors are currently doing, but they also see the potential for even more effective interaction and service delivery the longer the project is in place.

XI. INTERVIEW SUMMARIES: SCHOOL PERSONNEL (N=9)

Four guidance counselors, four principals, and one home economics teacher were interviewed.

1. How did you hear about AAHEP?

The home economics teacher responded that the school guidance counselor had introduced the AAHEP counselor to her, while all four principals and one guidance counselor learned of the project through their initial contact with the AAHEP counselor. Two counselors read about the project in the newspaper, and one followed the progress of the legislation from its initiation. Also, one principal received a notification from his superintendent informing him about the project.

2. What was your initial reaction to the project?

Two of the initial reactions were unreservedly positive, one from a principal and the other from a guidance counselor. Two principals expressed resentment that they had not been consulted and that new people were coming into their schools and working with students and even taking them off campus without notifying the office. The teacher and one counselor thought initially that project personnel were spread too thin, and one counselor viewed AAHEP as focusing only on one problem when there are so many. Initial reactions, of course, were flavored by the individuals' personal perspective and by the quality, scope, and source of the initial information.

3. What is your current reaction to the project?

After working with an AAHEP counselor, one guidance counselor changed her initial negative reaction to an extremely positive one. Two principals and one counselor were extremely positive, while one principal stated that he knew nothing about what was going on and one principal said that although he had not yet seen any results he was very hopeful that the mechanisms were currently in place for future interaction. Another counselor and the teacher (same school) felt that the counselors were spread too thin and should only be in one school. Several respondents mentioned the newness of the program and were confident that inter-actions would improve.

4. What has been your experience with the project and its staff (e.g., extent of involvement, action)?

Extent of involvement ranged from very extensive to none at all. As might be expected, the guidance counselors tended to be the most involved, and concomitant with the most extensive involvement were the most positive current reactions to the project.

5. When asked to rate each project objective, most respondents felt that they did not have enough information to do this.

6. Has AAHEP helped you? To what degree and how?

Four respondents mentioned that they saw the AAHEP counselor as another valuable resource for students in trouble.

7. What could be improved? If possible please give specific suggestions.

Suggested improvements included: increased time in the school, notification to principal that student is being taken off campus, more curriculum materials available, more follow-up with school personnel in specific cases, less project personnel turnover, and day care available for the continuation of schooling.

8. What are they doing well? Please specify.

Many positive comments were made about what the project is doing well, and most of these centered around the hard-working counselors. Also, most expressed that they hoped the project stays in place and that they felt that service delivery would become more efficient. Some felt that the counselors could not possibly do all they were supposed to do given the limitations of time and the transportation necessary in rural counties.

XI. DISSEMINATION

Management objective 3 speaks to dissemination:

Management 3: To evaluate the AAHEP and disseminate information about its purposes, programs, products and results (emphasis added).

Normally dissemination is thought of as a report of results, usually prepared as a research report and given at a conference or submitted as an article for publication. There are, however, other facets of dissemination, and especially for a project or activity that is relatively new.

The AAHEP is (October, 1983) just now beginning its second year of operation. The initial year of operation included considerable dissemination effort of one type--awareness. The AAHEP staff had to publicize the project, its purposes, programs and services. This dissemination effort took several forms.

Printed Material (brochures describing AAHEP, N=2).

Posters (about 500 at key sites with pockets to hold brochures).

Presentations to groups.

Inservice for teachers (10 school systems in August/September, 1983).

Meetings with key agency personnel (e.g., counselors in public schools, principals, ministers).

A-V Program, a slide-tape presentation (at Tennessee Nurses' Convention).

Cooperation with agencies (e.g., State Health Department).

Fairs, 2 county and 3 health fairs.

Media reports (e.g., news articles; TV and radio news spots; TV and radio interview programs).

Actual provision of services provides an effective form of dissemination.

Data provided the evaluators from AAHEP counselors and staff show the following "dissemination" efforts as part of the counselors' work and as part of the information collected by staff.

<u>Direct Contacts</u>		<u>News Clippings</u>	<u>Date</u>	<u>N</u>
<u>Agency</u>	<u>N</u>			
School	45	• <u>Tennessean</u> (Nashville)	1/3/83	1
Community Groups	53	• <u>Tennessee Register</u>	1/17/83	1
Churches	8	• <u>News-Sentinel</u> (Knoxville)	5/30/83	1
		• <u>Uncited</u>	-	1

A file of media releases kept by AAHEP contains 4 articles about AAHEP. This file represents a minimum, as there may have been articles in newspapers or even newsletters that did not come to the attention of the AAHEP staff. (More effort should be made to obtain important clippings.)

Meetings have been held with various groups and agencies to explain about AAHEP (e.g.):

Hospitals in Service area	(See also "Counselor Impact
Dept. of Human Services (State)	Statements," p. 35.)
Dept. of Public Health (Local)	Teacher Inservice

The AAHEP has engaged in a variety of dissemination activities related to project start-up. These dissemination activities can be classified as "awareness" efforts, or steps to publicize AAHEP and its services. The quantity and quality of these efforts seem commensurate with the purposes and with the first year of operation of a new project. AAHEP is to be commended, for example, for keeping a file of news clippings about the project and about similar projects and issues.

AAHEP was featured on WOKI's weekend report (half-hour) and 4-5 short interviews daily for a week. In addition, U-102 radio and a Morristown station did interviews. AAHEP was featured on the "Jeep and Ed Show" on cable in Morristown. The AAHEP story was sent out by UPI. (We do not know how many papers ran a story.) AAHEP was interviewed for a story in USA Today and featured on two local TV news shows (Channel 10 once and Channel 26 twice).

Some Suggestions

It would be useful to develop a dissemination plan to help AAHEP staff "target" their dissemination efforts to particular audiences and for particular purposes. Some checklist or reporting form might also be developed to keep track of major dissemination efforts. (A useful format for dissemination planning is presented in "Telling the NDN Story in 1983," a manual prepared by Max McConkey at The Network, Andover, MA. Portions of that are reproduced as samples and appear in Appendix F.)

A basic plan should consider at least four variables: the purpose of the communication, the audience or receiver, the communicator or "transmitter," and the channel or medium to be used. Additionally one should consider varying the presentation or communication (content, process) based upon these variables. Figure 9 shows a generic model for establishing

a dissemination plan, and Figure 10 shows an empty matrix for a dissemination plan which includes additional columns to assist with the mangement/evaluation function. Figure 9 is an actual model from a different project. This format might work for AAHEP, but the entries in the matrix must be adjusted to fit the needs of AAHEP.

Appendix F includes sample pages from "Telling the NDN Story." These pages may provide ideas that will be useful in setting up a dissemination plan if a few adaptations were made to accommodate AAHEP's focus.

AAHEP staff should continue to collect published information about AAHEP. These clippings will constitute a record of "awareness" dissemination efforts and would be useful in other ways for evaluation. A scrapbook might be a suitable way to display these clippings, or the project can continue to keep a file.

STAGE OF CHANGE Process (Message) (Purpose)	FACILITATORS (Transmitters)	CHANNELS OF COMMUNICATION	AUDIENCES (Receivers)
<u>AWARENESS,</u> <u>INTEREST</u> <u>DISSEMINATION</u>	University, SEA, Fed. personnel; special consultants; representatives from model programs; R&D specialists.	Conferences, professional journals, printed materials, audio-visual presentations, displays, tours of model programs. One-way and mass communication.	Broad groups of teachers, administrators and members of power structure (school board, government, etc.)
<u>EVALUATION,</u> <u>TRIAL</u> <u>DEMONSTRATION</u>	SEA specialists; personnel from regional colleges and universities; LEA training specialists from outside immediate area.	Demonstration of new practices, small group workshops, university problem courses and field-based courses, inservice interest groups, competency-based mini-courses, teacher exchanges.	Small groups in school setting where possible with emphasis on leaders of informal organizations and opinion leaders.
<u>IMPLEMENTATION</u> <u>(Adoption or</u> <u>Institutionalization</u> <u>and leading to</u> <u>Diffusion)</u> <u>DIFFUSION</u>	LEA specialists from similar but not nearby systems; diffusion specialists from exemplary programs; field professors; special consultants; local opinion leaders.	One-to-one help in target person's work situation; face-to-face sessions stressing two-way communication. (Essentially coaching.)	Individuals or small work groups (two or three persons). Role-alike group.

Figure 9. A PROPOSED CHANGE/COMMUNICATION MODEL TO INCREASE THE PROBABILITIES OF DIFFUSION OF NEW IDEAS, PRACTICES OR MATERIALS (ACHILLES AND NORMAN: 1974. MODIFIED)
(Examples are from another funded project. Needs modification for AAFED.)

ELEMENTS OF COMMUNICATION

MANAGEMENT/EVALUATION STEPS

	Stage of Change Process (Messages)	Facilitators (Transmitters)	Channels or Processes	Audiences or Target (Receivers)	Purpose	Results Action/Taken	Evaluation: Methods/Outcomes
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
DISSEMINATION	Awareness Interest (Initiation; Mobilization) Knowledge						
	<u>Evaluation</u> <u>Trial</u> (Implementation) Persuasion and Decision						
	<u>Adoption or</u> <u>Adaptation</u> (Incorporation) Confirmation						

Figure 10. Communication/Change Matrix Relating Communication Theory and Change Process as a Basis for Categorizing Dissemination Activities. Columns 5-7 --- and additional ones that might be added -- will provide direction and assist in analysis of data. Terms in () are from RAND (Berman and McLaughlin), terms underlined are from Rogers (1962), and other terminology is Rogers and Shoemaker (1971). The basic model is in Achilles and Norman (1974). The expanded version is in several Tennessee State Facilitator Project (TSFP) proposals and in several later replication and change models.

XIII. CONCLUSIONS AND RECOMMENDATIONS

Goals and Program Objectives.

The goals and objectives of AAHEP form the structure around which conclusions of the evaluation team and its recommendations are centered. In as much as goals and objectives form targets toward which the project was directing its efforts during the year, these goals and objectives are the most reasonable standards against which to measure the project's accomplishments. (See Figure 1, pages 4-7.)

Goal 1: To reduce adolescent premarital sexual relations and adolescent pregnancy.

Conclusions. Indirect measures are the only avenue for judging progress toward reducing premarital sexual relations among adolescents. Preliminary data indicate that adolescent pregnancy is declining and abortions have diminished. It is impossible to state that these declines resulted directly and solely from AAHEP efforts. It does indicate, however, that the initiatives taken by the project staff members are producing results that take the project in the desired direction.

Recommendations. The single activity likely to continue to impact on the frequency of premarital sexual relations and pregnancies among adolescents is education. Prevention activities initiated by AAHEP should continue with increased emphasis placed on reaching adolescents before pregnancy occurs.

Counseling has been shown to be a valued and valuable part of AAHEP. For those young women who have given birth, continued counseling should be available, either by AAHEP staff or by staff members of other agencies, to help reduce the risk of a secondary pregnancy. In many cases, it appears that the emotional support supplied by counselors can become a deterrent to the young person who has experienced her first childbirth.

Goal 2: To improve the level of medical and developmental care provided to pregnant adolescents.

Conclusions. Trends in pre-natal medical care indicate that the level of care is improving. The percentage of persons visiting a physician 3-6 times during pregnancy is dropping while the number visiting physicians 11-14 and 15-20 times is increasing. Similarly, the percentage of pregnant adolescents who receive first and second trimester pre-natal care is increasing. Finally, the number of low birth weight babies born to clients who received AAHEP services is lower than those who had become clients after the birth of their children. Although it is impossible to state that AAHEP was causal in this relationship, it does lead one to conclude that AAHEP services can be a tool for securing the necessary medical assistance to reduce the incidence of low birth weights.

Data indicate that clients do take advantage of available medical services when these services are known and accessible. The primary reason these services haven't been fully used is lack of information. A second cause is lack of transportation. Both concerns have been addressed by AAHEP. Clients and their families uniformly stated that they knew nothing

about available services and would not have taken advantage of them without the assistance of the AAHEP counselor. Similarly, without transportation provided by counselors, some pregnant adolescents would have received substantially less medical attention.

Close working relationships with hospitals and other health care providers are important to the achievement of this goal. Good working relationships have been developed with some hospitals, an agreement has been reached with the Department of Health and Environment, and cooperation with the Department of Human Services is growing. These are all important, critical relationships in working toward the improvement of the level of medical and developmental care provided to pregnant adolescents.

Recommendations. In order to strengthen the project's relationship with medical care providers, staff members should take every opportunity to build on the good relationships already established with at least two hospitals in the area; these types of relationships should be expanded to additional hospitals. The staff might, for instance, assemble a medical advisory panel to meet periodically to provide advice. In addition to receiving the advice, such a step would announce to the medical community that their perspectives are important to the project and that they are welcome participants.

The level of transportation support provided for clients should not diminish. The evaluators are aware of budgetary constraints surrounding transportation in 1984. But, the data show that without transportation many clients simply would not have received services. Although it is difficult to understand that any 20th century American can live as an isolate, this condition seems to exist in this rural, isolated area. The isolation and poverty of some of the clients, coupled with a cultural inhibition toward seeking "outside" help, make transportation a critical tool in meeting project goals and objectives. Any budget adjustment possible should be made to provide a level of transportation support necessary to maintain the momentum of project efforts.

Personalized follow-up with adolescent mothers is important to help maintain the health of both mother and child, to help reduce unwanted second pregnancies, and to assist in building a supportive atmosphere in the home. Data from post-natal clients indicate that many services are needed. Hopefully, by reaching clients earlier in their pregnancy, fewer post-natal services will be required. But, it is unlikely that the need for services will ever be eliminated. A program of personalized follow-up should be followed and efforts by counselors to provide such follow-up should continue.

Objective 1: To coordinate available prevention and care services to maximize the impact of existing programs.

Conclusions. Referrals are the primary source of information about coordinating available services. Despite the late initiation of field work and the early struggles faced by counselors, the project has built a strong network for cooperation and coordination. Counselors made more than 300 referrals and were the recipients of more than 250 referrals. Of equal importance, counselors stated that the rate of referrals is

continuing to grow. This indicates that counselors have become accepted in their communities, are viewed as valuable resources, and have developed good working relationships with other agency personnel.

AAHEP's primary prevention effort has been with schools. This is undoubtedly the most cost-effective area in which to concentrate prevention activities. According to school personnel, the efforts are welcomed, they are judged to be of high quality, and they provide a needed service that would be otherwise lacking. More importantly, due to the sensitive nature of prevention activities, the manner in which counselors conduct themselves and their work is as important as the work itself. In all cases, counselors were lauded for their sensitivity to community concerns, their ability to work successfully with students and teachers, and their commitment to clients.

Recommendations. Coordination of available services is obviously occurring and increasing in frequency. In addition to maintaining the use of available resources, steps should be taken to refine further these working relationships. Meetings should be convened to allow personnel from a broad spectrum of services to apprise their colleagues of the most effective manner for obtaining services. AAHEP counselors should be familiar with the details of and procedures for referrals to the several agencies. This is not to imply that counselors do not now possess knowledge of the necessary procedures. Rather, the evaluators see some value to formalizing the acquisition of this knowledge, not only for the benefit of the knowledge received, but also as a device for informing personnel in cooperating agencies of AAHEP's interest in building the strongest possible working relationship.

Objective 2: To make additional resource personnel available to adolescents and their families.

Conclusion. Data concerning referrals, statements by clients and their families, and statements by school and agency personnel all clearly indicate that the project is meeting this objective. In addition, the range of services provided to clients indicates that all available resource personnel have been made available and are making a difference in the lives of pregnant adolescents and their families.

Recommendations. Counselors should continue to search for additional resources. In some counties, additional professional resources clearly are not available. In all counties, however, volunteers are resources that can be helpful. Volunteers may be one way to reduce or shift counselor load. Counselors might employ volunteers to make house calls, for follow-up, for outreach, and some transportation.

The use of volunteers, as an additional resource, can be aided by the development and conduct of volunteer training sessions. Such sessions should be designed by central staff members and made available at times appropriate to the needs of specific counselors. Although this step would increase work loads, it could prove to be a cost-beneficial way to diminish the intensity of counselor responsibilities, at the same time providing a broader base of services to clients.

Objective 3: To generate the resources needed to continue AAHEP's services in the absence of federal funds.

Conclusions. No specific steps toward meeting this objective were taken during the first year. This is understandable, since the primary focus for this year was establishing the project, developing working relationships, and initiating services. The work accomplished this year, however, should provide a solid basis for pursuing this objective in the future.

Recommendations. The staff should begin to develop a plan for generating such resources. The plan should contain a description of the types of working arrangements needed between/among agencies, consideration of functions that could be performed by a number of agencies, suggestions for altering the structure of delivering existing services, as well as potential sources for funds. Cooperative relationships and networks will be useful here.

Objective 4: To arrange for appropriate utilization of pre-natal and post-natal services by adolescents regardless of their proximity to available services.

Conclusions. Examination of the types of services provided indicates that differences exist between services for pre-natal and post-natal referral groups. In both groups, personnel counseling was the primary service rendered. In the pre-natal group, health and family counseling formed the second and third most frequent services. In the post-natal group educational and vocational services and parenting education formed the second and third most frequent services utilized. In addition, this group required more intense service than those who had received pre-natal assistance. Referrals also differed between the two groups. The pre-natal group primarily received health and financial assistance while in the post-natal group the emphasis was on financial and future oriented services. These distinctions, while small, indicate that services appropriate to the two groups were provided and that a wide range of services was made available.

Due to the relative isolation of the homes of many of the clients, many of the services were provided by transporting clients to a service-delivery location. The issue of transportation was discussed above. It is sufficient to note at this point that the transportation provided is evidence of staff members working to achieve this objective.

Recommendations. The evaluators cannot make recommendations toward meeting this objective that have not been made earlier. Maintain a range of services to fit needs of both pre- and post-natal groups. Continue to provide follow-up to post-natal clients. Finally, do whatever is possible, including the use of volunteers, to provide transportation.

Objective 5: To provide individual assistance to pregnant adolescents in making arrangements for their delivery.

Conclusions. Counseling has been the primary vehicle for providing individual assistance. Through the counseling encounter, counselors have determined specific needs of individuals, developed plans for providing services, and initiated contact with appropriate resources. While this approach is time consuming, it does provide an excellent format to insure

attention to individual needs.

Recommendations. Recommendations made above regarding the search for additional resources, provision of transportation, and developing existing resources into a more articulated effort apply to this objective as well. In addition, it may be helpful to develop a pamphlet that lists steps that should be taken by every pregnant adolescent to prepare for delivery. Such a pamphlet could be shared with family members and clergy as well as clients.

Objective 6: To provide more adequate education for adolescents related to sexuality including continuous availability of information.

Conclusions. Education programs are operating in 45 schools in the area. These programs operated in connection with schools' counseling programs and with classroom teachers. AAHEP counselors are speaking to classes and are working with principals, home economics teachers, biology teachers, physical education teachers, and health teachers to develop materials for inclusion in their own lesson plans. Some counselors indicate that they need assistance in developing curricular materials for use by teachers.

Equipment for use in outreach and educational presentations continues to present logistical problems. Housing the equipment at a central location such as Knoxville requires travel by all counselors in order to use the equipment. A complete set of equipment for each counselor is a costly alternative.

Recommendations. Present plans to target staff efforts in fewer schools should result in more comprehensive services to teachers and school counselors. To raise the quality of that service, staff development efforts include curriculum development for those counselors who need the assistance.

Targeting efforts in 1984 will also relieve some of the logistical problems associated with the use of audio-visual equipment. Although counselors do make use of borrowed equipment, it may be necessary to borrow such equipment even more frequently. It is recognized that this is not an optimal solution, but it may be the only one that is viable.

Objective 7: To create a system for involving families and religious organizations in the education of adolescents related to sexual responsibilities.

Conclusions. At this time involvement of families and religious organizations has been on an idiosyncratic basis. Most of the family involvement has been related to providing services to pregnant adolescents. This has been a very important aspect of the service to the pregnant client. These services have included counseling for teen fathers and parents, assisting families in dealing with the emotional stress of the teen pregnancy, and transportation that the family could not provide. As a result a large proportion of the teenagers who have delivered babies are living with family members or extended families. Thus, according to the information on hand at this time, family members have learned to be more understanding and supportive and are more aware and concerned about the health of the teenager and the baby. Such an outcome is clearly of benefit to the entire family.

Contacts with church organizations have been made with individual members of the clergy. As was pointed out in the Interim Report (p. 21), large scale involvement with churches is unlikely. Although church involvement has not yet been large (8), the approach taken has been cautious and reasonable.

A "system" for involving families and religious organizations is not apparent, but the evaluators do not view this with concern. The personal basis upon which this objective has been pursued is the most reasonable approach given the culture of the area.

Recommendations. AAHEP should maintain its individual approach to involving families and religious organizations. The families most in need of involvement are those dealing with a teenage pregnancy. It is prudent to focus resources on those families most in need and allow the pool of families served to grow gradually.

Similarly, after acceptance in the community, counselors are finding it easier to involve churches. This effort, too, will result in successful relationships as family involvement grows and as individual clergy become involved with the project.

Conclusions and Recommendations for the Management Objectives.

Management Objective 1. To Establish and Maintain AAHEP in the Target Area.

Conclusions. After some initial "start-up" problems, including the need to establish a new set of field offices, staffing concerns, etc., AAHEP is up and going. Staff overcame initial barriers. Observation, field visits, reports and program files substantiate that AAHEP is an entity of three administrative personnel, nine counselors and adequate support staff. Now that start-up efforts have been successful, there needs to be increased attention to steps related to maintenance and refinement of AAHEP.

Recommendation. The AAHEP staff should focus on maintenance efforts and ways to refine or streamline the project. As recommended in a 6/16/83 letter from HSS, it would be useful to establish a central facility where the director, and associate directors for counseling and education can be housed together to insure regular formal and informal contact. (Initial steps have been taken). Staff would use this central facility as needed.

Management Objective 2. To Manage, Operate and Evaluate the Progress of AAHEP.

Conclusions. Accomplishment of goals and objectives has been addressed throughout this report. In general each goal and objective has been met at least at a satisfactory level. The project fell short in reaching its projected number of clients the first year. It was difficult to separate care and prevention efforts with a high degree of precision. Travel consumed a considerable portion of staff time.

The AAHEP operated within its budget constraints. An independent audit was held. Matching funds were obtained. This objective was met successfully. A microcomputer was installed near the end of the first

year (late July) to help with management and evaluation. A July letter from HSS suggested that "availability of a computer system will facilitate the project's participation in the cross-project efforts of OAPP." Reports and the proposal for continuation were completed in a timely fashion. Data collection forms and formats were changed during the year, and some data were incomplete. However, these cases were rare and often were able to be corrected.

Staff communications need improvement and counselors express a need for additional involvement in some AAHEP efforts (e.g., development of continuation proposal).

Recommendations. There should be some adjustment of project focus to improve management and impact (Steps have been taken). Staff should meet to see if some objectives should be adjusted to changed, or to see if some should be deleted or added to reflect the move from initiation to operation.

There should be some reassessment of the number of clients that the project will reach. Data collection formats should be checked to see if they can become more sensitive to distributing care and prevention efforts (for management and evaluation efforts).

Attention should be paid to improving organizational and personal communications. Administration should determine if there are meaningful ways to involve counselors in some administration-type efforts, such as providing ideas and input for plans and proposals. The director should become more involved in staff meetings and daily staff interactions as a means of opening communication.

The microcomputer should become an integral part of the management and evaluation system of AAHEP. (This is in process). As the system becomes operational, monthly data reports can become available for administration and evaluators.

Management Objective 3. To Evaluate the AAHEP and Disseminate Information About its Purposes, Programs, Products and Results.

Dissemination

Conclusions. As AAHEP becomes more established and better known, it seems that more and more referral sources are becoming known (from interview summaries; data on referrals). AAHEP administration should consider spending more time on establishing structured dissemination processes.

AAHEP has engaged in considerable dissemination effort. Dissemination has been primarily "awareness" or getting the word out about AAHEP. Personal contacts and meetings, brochures (N=2) and media reports were the major modes of dissemination.

Dissemination of project results should be planned now that some data are available. It is anticipated that dissemination of positive results to key persons will improve the image of AAHEP and result in additional referrals.

Only 4 media reports were in the AAHEP file. This suggests one of two situations: 1) either AAHEP staff have not identified and collected

the media reports or 2) AAHEP staff should increase its attention to getting information to the media. However, as noted in the Dissemination Section, there were numerous other media "events": TV, radio, interviews, etc. The dissemination file needs more attention.

Recommendations. Perhaps AAHEP could plan to be on the program at area professional meetings, such as East Tennessee Education Association (ETEA), or at the programs of the Upper East Tennessee Educational Cooperative (UETEC) in Johnson City, TN. Contact should be established through the regional office of the State Department of Education.

The staff should consider developing a dissemination plan to guide dissemination efforts and provide a better base for evaluation efforts related to dissemination. Appendix F includes material that may be helpful in developing a dissemination plan.

Evaluation

Conclusions. Data were regularly collected from counselors regarding their activities and contacts. In August, 1983, an Apple microcomputer was installed. This should help streamline the collection of data for management and evaluation. Evaluators provided an Interim Evaluation Report (May, 1983). The current Report includes information, conclusions and recommendations based on evaluation and management data collected October 1, 1982 - September 30, 1983.

Recommendation. Project staff should provide periodic computer printouts to the evaluators so they can have a sense of project progress. Final evaluation efforts should start in July, but can't be completed until school is in session, if schools will be a major data source. Comparisons with baseline may be one way of showing project impact, but a more realistic way seems to be an assessment of the impact of AAHEP on specific clients (and, perhaps, agencies).

Name: _____

Date: _____

Questions for Counselors

1. Comments

2. What goals did you set for yourself for 1982-83?
3. How well, on a scale of 1 (not very well) to 5 (very well), do you think you met the goals which you set for yourself? _____
4. What specific goals are you setting for yourself in the next few months, for the next year?
5. Rate the project. On a scale of 1 (not very well) to 5 (very well), rate to what extent you feel the project is meeting its objectives.

<u>Objective</u>	<u>Rating</u>	<u>Not Applicable</u> <u>Don't Know</u>	<u>Comment</u>
1) To coordinate available prevention and care services to maximize the impact of existing programs.			
2) To make additional resource personnel available to adolescents and their families.			
3) To generate the resources needed to continue AAHEP's services in the absence of federal funding.			
4) To arrange appropriate utilization of pre-natal and post-natal services by adolescents regardless of their proximity to available services.			

C-1

<u>Objectives</u>	<u>Rating</u>	<u>Not Applicable Don't Know</u>	<u>Comment</u>
5) To provide individual assistance to pregnant adolescents in making arrangement for their delivery.			
6) To provide more adequate education of adolescents related to sexuality including continuous availability of information.			
7) To create a system for involving families and religious organizations in the education of adolescents related to sexual responsibility.			

6. What things are, in your opinion, being done well? Specify.
7. What things could use improvement? Include, if possible, specific suggestions.
8. What are your perceptions about the reaction of other agencies to the project? Give example.
9. What are your perceptions about the general reaction of clients to the program? Give examples.
10. What do you see as your biggest problem?
11. What do you think you and the project do particularly well?
12. What suggestions would you give the supervisory staff in order to help you, the project, etc.?

13. What suggestions would you give the administrative staff in order to help you, the project, etc.?

14. List that you work with: [PREVENTION]

	Number	Quality (on a scale of 1 = very poor to 5 = excellent, or NA)
<u>Schools</u>		
<u>Churches</u>		
<u>Community Agencies</u>		

Client: _____

County: _____

Delivery Date: _____

PRENATAL

Date of Referral,
Source, Trimester*

AAHEP services offered
(counseling/referrals) and date

List agencies contacted for ser-
vices, date, contact person

Service(s) provided
by agency

Trimester

CL-1

POSTNATAL

Living Arrangements
Teen parent/Child

LRW? 5.5
lbs. or less

AAHEP services
offered and date

List agencies contacted for services, date,
contact person, for teen parent, for baby

Service(s) provided
by agency

Was transportation
provided?

B-1

*If the initial contact occurred after delivery, please indicate here and go to Postnatal section.

☐

(Over)

Services to teen father:

Services to family:

What is the teen parent doing now?

What services (not listed) were provided?

I.D. _____

Date _____

Interview Guide for Delivered Mothers

1. How did you learn about this counselor?
2. What did the counselor do for you?
3. What would you have done without this counselor?
4. What helped you the most?
5. What do you still need?
6. Did the counselor talk with the baby's father? How often?
How did he feel about it?
7. Did your parents talk to the counselor? How often? How
did they feel about it?
8. What are you thinking about for your immediate future plans?
For the baby? For yourself?
9. What other people (agencies) are helping you now? Did the AAHEP
counselor help you get in touch with them? What are they doing
for you? How good do you believe this help is?
10. How would you rate the services you received from AAHEP?

DM-1

I.D. _____

Date _____

Questions for Health Providers

1. Did you discern any difference in AAHEP teen clients from other non-AAHEP pregnant teens? Examples?

2. What benefit do you believe that these clients derive from involvement in AAHEP?

3. What services or information could/should AAHEP provide to improve their services (e.g., to prepare clients better for delivery)?

4. What procedures should AAHEP institute that would enable your agency to act more effectively with such clients?

HP-1

D-1

Name _____

Organization _____

Date _____

Position _____

Questions for School, Religious,
Youth Group and Community Personnel

1. How did you hear about AAHEP?
2. What was your initial reaction to the project?
3. What is your current reaction to the project?
4. What has been your experience with the project and its staff
(e.g., extent of involvement, action)?
5. Following is a list of AAHEP project objectives. Please rate each one
on a scale of 1 = not very well to 5 = very well as to your perception
of the degree to which AAHEP is meeting its objectives of prevention
and care.

<u>Objective</u>	<u>Rating</u>	<u>Not Applicable Don't Know</u>	<u>Comment</u>
1) To coordinate available pre- vention and care services to maximize the impact of exist- ing programs.			
2) To make additional resource personnel available to ado- lescents and their families.			
3) To generate the resources needed to continue AAHEP's services in the absence of federal funding.			
4) To arrange appropriate uti- lization of pre-natal and post-natal services by ado- lescents regardless of their proximity to available ser- vices.			
5) To provide individual assis- tance to pregnant adolescents in making arrangement for their delivery.			

A-1

BEST COPY AVAILABLE

<u>Objective</u>	<u>Rating</u>	<u>Not Applicable Don't Know</u>	<u>Comment</u>
6) To provide more adequate education of adolescents related to sexuality including continuous availability of information.			
7) To create a system for involving families and religious organizations in the education of adolescents related to sexual responsibility.			

6. Has AAHEP helped you? To what degree and how?

7. What could be improved? If possible please give specific suggestions?

8. What are they doing well? Please specify.

COMMUNICATION CHECKLIST/SCORECARD

Program _____
 Individual Completing Checklist _____
 Date _____ D/D _____ SF _____

Instructions: Please check (✓) those communication activities which you feel your project can accomplish during 1983 along with the frequency you feel you can do each activity.

Possible Activities	I Will Do:		# of Between 1/1/83 - 12/31/83	Frequency							
	Yes	No		Monthly		2/Year		1/Year		As Needed	
				Yes	No	Yes	No	Yes	No		
1. Add national and state legislators to my mailing list.											
2. Send an information letter to the superintendent or appropriate administrator of each adopting district within 1 month after initial training has taken place.											
3. Send an information letter to the appropriate national and state legislators 1 month after initial training has taken place.											
4. Encourage adopter district to communicate with state and national legislators regarding the NDN and the benefits their district has received by adopting an NDN program.											
5. Send a press release to local news media within 1 month after training/evaluation has been completed.											
6. Invite state and national legislators and/or their aides to visit adoption/demonstration sites.											
7. Develop profile of D/D program for use by other D/D's and SF's.											
8. Meet with one or more state legislator(s) and/or their aides to discuss your program with them and your role in the NDN.				Name of your target state legislators: 1. _____ 2. _____ 3. _____							
9. Meet with one or more national legislator(s) and/or their aides (in-state or in Washington, D.C.) to discuss your program and your role in the NDN.				Name of your target national legislators: 1. _____ 2. _____ 3. _____							

INDIVIDUAL PLAN

AUDIENCE

MESSAGES

MEDIA	TIMELINE

INDIVIDUAL PLAN

SAMPLE

AUDIENCE
Superintendent

TO WHOM?

MESSAGES
This program will reduce the dropout rate of the local high school

WHAT?

MEDIA	TIMELINE
1. Local newspaper	bimonthly
2. Invite superintendent to speak at project events	ongoing
3. Presentation at Board of Education meeting	September & March
4. Personal contact between students and superintendent	ongoing
5. Student testimonies	March
6. Parent Support evidenced through letters & personal contact	ongoing
7. Etc.	

HOW?

BY WHEN?